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ABSTRACT

This report discusses world-wide efforts to provide health services in centers that are outside institutions and provide ambulatory care in the patient's home. Emergency services, although a form of primary care, are dealt with only to the extent that they are part of an organization designed to provide general primary care, but not where they are independent or attached to a hospital. Topics covered are: (1) staffing patterns of primary health care centers; (2) teamwork within the centers; (3) range of services provided; (4) record keeping and information utilization in patient care; (5) management and decision making; (6) organizational structures; (7) primary health care and the community; (8) financing of centers; and (9) distinctions between socialized and pluralistic systems of primary health care. (JD)

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World Health Organization
Regional Office for Europe
Copenhagen

Public Health in Europe 22

The health centre concept in primary health care

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1

General observations

What are the best possible health services? There is no universally applicable answer to that question simply because of the dynamic nature of the concept of health, and variations in health needs and the resources to deal with them. What is "best" must be determined in the light of existing knowledge and technology; what is "possible" is dictated not only by financial constraints but also by the time-lag inherent in the production of new types of personnel or the changing of existing types, as well as in the creation of new facilities or equipment. This time-lag tends to impart a certain degree of rigidity into any health service system and, unless the functioning of the system is reviewed periodically, there is the danger either that it will become fossilized or, when change becomes imperative (as, for instance, in times of financial cutbacks), that it will be implemented on the basis of expediency and without regard to its implications for the whole system.

Not so many years ago, general practice was considered obsolete in an era of rapidly advancing medical knowledge that could be mastered only by specialists concentrating on smaller and smaller areas of medical science and skill. The hospital with its sophisticated equipment became the logical place to be, when sick; the faith in an infinite ability to cure disease diminished concern with prevention. More recently, however, the recognition grew of the human being as something more than just an assembly of parts, of the need to coordinate various specialized approaches, and of certain potential disadvantages arising from avoidable hospitalization. The limited ability of medicine to cure chronic and degenerative disease rekindled interest in prevention and health maintenance, which had proven so effective with regard to communicable diseases. Primary care began to come into its own again, but not as something based on the traditional solo practitioner. General practice broadened into becoming a specialty of its own, and it soon became recognized that, to be fully effective, the physician must be supported by other professionals and particularly by those who could cater to people's personal and social needs.

All these changes have occurred to a different extent and over different periods in different parts of the world. Poorer countries have

seen too many sophisticated resources concentrated in too few places. More affluent countries have suddenly been made aware of limitations even to their resources, and it is this sudden economic squeeze rather than the earlier recognition of real health needs which is bringing about a reappraisal of the role of primary care.

Between the resistance to change of a rigid system and the urge to change because of sudden economic constraints, there is the danger of precipitate solutions being attempted without balancing the needs of various population groups and the potential supply and use of health resources.

Those studying the health needs of populations and of particular high-risk groups have been aware for some time that the physician, however well qualified, and the hospital, however well equipped, are no longer sufficient to provide the care many patients require and modern medicine can provide. Physicians have become increasingly specialized and thus able to provide better care for specific health problems. Facilities and equipment also have become more sophisticated, permitting successful intervention in cases where this was previously unknown. These advances are likely to continue and, to the extent that they do, will bring about new and more efficacious ways of diagnosing or treating particular illnesses. All this leads to health services of greater complexity but it also contains the danger of increasing fragmentation unless deliberate steps are taken to coordinate proliferating activities. General medicine, which had lost some of its status to the more spectacular specialties, is coming into its own again, not to replace the specialties but to permit their fully effective application, which depends on the recognition of the need to see people as wholes and not just in terms of isolated episodes. A new understanding of the effects on health of people's lifestyles and of the environment has led to new approaches to health maintenance and the prevention of illness. The possibilities of physical and mental rehabilitation and the recognition of the substantial social needs of certain categories of patients have broadened the range of activities that constitute an effective modern health service. This broadened recognition of health needs has led to new categories of personnel, new procedures, and the addition of new equipment to the armamentarium of the health services. The result has been the concept of the health team – long accepted in the hospital setting where doctors, nurses, therapists, technicians and often social workers, as well as administrators, have come to work together. This cogwheel concept has been extended to health services outside the hospital, and many countries have long and substantial experience of various ways of organizing such services.

These services have been variously designated as primary, ambulatory, or community services but none of these terms is quite appropriate, since the services in question are of both a primary and a continuing nature and the hospital is, or should be considered as, part of community resources. Moreover, there is no clear dividing line between the hospital and other institutions for the care of, for instance,

the elderly or handicapped. The term "community services" is also often used to cover residential institutions other than the hospital, and the patients may not be ambulant but bedridden, even though not in hospital.

What this report is about is the organization of services that are outside institutions and provide ambulatory care and care in the patient's home. This constitutes "primary care" as the term is used in this report. Emergency services, although a form of primary care, will be dealt with only to the extent that they are part of an organization designed to provide general primary care, but not where they are independent or attached to a hospital.

If the range of services referred to above is to be made available to the ambulatory as well as the homebound patient, some form of organization is required to provide the necessary personnel and equipment; the term "health centre", as used in this report, is intended to cover the variety of organizational patterns adopted for this purpose in different countries and within countries.

Such organizational forms have developed in different countries to a varying extent because they have been recognized as essential to good health care. In some countries certain forms of health centre are part and parcel of the national health service system, in others they are experimental or have been set up as demonstration projects.

If this development originated in the recognition of health needs in the community, it has of recent years been powerfully reinforced by the critical examination of health service costs. Economic considerations have in many countries led either to cuts in the health budget or to strict limitations on future increases. Since, in most places, the hospital has been the most costly component of the health services, it has become the main target of cost constraints. There is, of course, the likelihood that, apart from the elimination of obvious waste, financial constraints bring about a corresponding deterioration in services, unless at least equally good alternatives for providing the services are found. In the case of the hospital, the alternative now frequently proposed is a strengthening of the primary care sector. This is an area in which planning directions in both industrialized and non-industrialized parts of the world coincide, even if the cost levels are still very different. A passage from a WHO document[a] aptly summarizes the many proposals that have emerged in various countries:

> On the international forum attention has been redrawn to the concepts of primary health care and simplified health technologies which could be effectively applied in preventive, curative and restorative health care. The concept of primary health care is not restricted to developing countries. The need to strengthen "front-line care" has been discussed for many years in industrialized countries, and some of them have remarkable achievements in

[a] Kleckowski, B. M. et al. *Comments on causes and possible cost containment measures.* Geneva, ILO and WHO, 1977 (unpublished document RCMC/1977/D. 5).

this field. The appropriate technology for such health care has also been debated and tried. Some countries are providing it through dispensaries, some through general practitioners or group practice, and yet others through integrated and regionalized health services in which allocation of various medical technologies can be achieved even in a more rational and economic way.

Thus, for once, concepts of good care have been found to coincide with the aims of cost-conscious administrators, the result being the development of a great variety of organizational technologies, each influenced by priority needs, the available resources, and traditional health service patterns.

Because many countries are still searching for suitable ways of organizing primary care services, it should be helpful to them to have an account of alternative approaches to a basically similar problem. The European Region of WHO comprises countries at widely different levels of industrialization, with climates ranging from the arctic to the subtropical. Findings from the various parts of the European Region should therefore have applications in corresponding situations in the other WHO regions.

To summarize briefly the objectives of this report, it will be found that in most, if not all, countries there is a need to strengthen primary care services and broaden their scope beyond that of the services that a general practitioner can provide single-handed. This arises from an assessment of what constitutes good patient care, as well as from the necessity of providing good care as efficiently as possible, specifically by limiting costly hospital services to those services that the hospital is best suited to supply.

Sources of information

Two methods of gathering information were used. First, a letter was sent to all Member States in the Region, asking them to describe the forms of primary care organization existing in their country. Second, some countries in the Region were visited to obtain more details on the structure and operation of organizations of the health-centre type. The selection of countries was bound to be arbitrary to some extent, because no one health care system can be said to be exactly typical, but the countries selected do represent two broad categories of system, i.e. the pluralistic system with a public as well as a substantial private sector (as in France and the Federal Republic of Germany) and the largely public and centrally planned and/or operated systems such as those in the eastern European countries, Scandinavia and the United Kingdom.

Both the circular letter sent out by the Regional Office and visits followed the same line of enquiry, but the specificity of the information obtained varied considerably, as was bound to be the case, in both approaches.

This report is not a complete review of the forms of organization of primary care existing in the European Region; this was not possible with

the time and resources available. Consequently, some interesting approaches to the health centre concept may have been omitted and the Regional Office would appreciate it, if such instances were brought to its attention for future reference. For the present, however, it is hoped that sufficient variations on the theme are described here to arouse interest and stimulate further study and discussion, thus placing health administrations in a better position to evaluate the situation in their own countries.

Organization of health care outside the hospital

That the hospital requires an increasingly complex organization has been taken for granted. The hospital is the repository of sophisticated equipment, it is the field of activity for a wide range of health professionals, it provides various hotel services in addition to medical care, and by its very nature it requires administrative and maintenance services. To ensure the smooth interaction of these various cogwheels, a definite organizational structure is necessary and has indeed evolved.

Health services outside the hospital—variously but inadequately referred to as primary, ambulatory, or community services—have however remained largely fragmented in most countries. In as labour-intensive an industry as the health services, the distribution of manpower reflects the differing degrees of organization. In the health service of an industrialized country one may expect to find, for every physician, about 15 other workers, but these have until recently been concentrated in the hospitals so that the comparative distribution may be something like this:

	Personnel per physician	
	In hospital	*Outside hospital*
Nursing and midwifery staff	12	1.1
Technicians	2	0.3
Administrative and other staff	11	—
Total	25	1.4

As the emphasis shifts from care in the hospital to primary care outside, it becomes obvious that primary care must be equipped to perform its new tasks. The revival of primary care and the consequent shift in the distribution of tasks in many parts of the world is a phenomenon of the last decade or so, and in 1970 Roemer (*1*) observed that "from a global perspective on health service, we seem to be entering a period when the major social focus is shifting from hospital care to care of the ambulatory patient". In his worldwide review of the primary care scene, Roemer observed five types of organization: (1) separate dispensaries for treatment of the sick; (2) hospital outpatient departments; (3) specialized preventive clinics under public health agencies, industries, or schools; (4) private group medical practice, and (5) health centres of either preventive or integrated preventive-curative scope. This

has remained a useful categorization, but all attempts at strictly classifying human services necessarily result in oversimplification because of the continuum presented by human needs and the variations in their recognition by society. Terminology is another confounding factor especially when different languages are involved; but, even in the same language, terms such as "health centre", "dispensary", "group practice" or "polyclinic" may mean different things in different countries.

Nor is the distinction between hospital care and outside care always clear-cut. Hospitals may have day or night patients, while health centres may have beds for some of their patients, and the dividing line between medical care on the one hand and social and custodial care on the other is often blurred. This is one of the things that makes it difficult to agree on a precise term for the kind of activity or organization discussed in this report. "Primary" or first access care may be limited to the general physician and his supporting staff, but in other situations it may involve internists, paediatricians, gynaecologists and, in some health care systems, any specialist. "Ambulatory" care, strictly interpreted, excludes the bedridden patient at home. "Community" care, meaning care outside the hospital, would be the most appropriate term for the purposes of this discussion, but it conveys the unfortunate notion that the hospital is not part of the community and not integrated with other community resources. "Outpatients" are generally understood as those using the outpatient department of a hospital. The *Glossary of health care terminology* published by WHO (*2*) illustrates those semantic difficulties. Where the above terms are used in the following text, they should be considered as interchangeable and as referring to services other than those provided to inpatients at a hospital.

It would be just as detrimental to effective and efficient health care to develop primary care services in isolation from the hospital as it would be to plan hospital services without regard to primary care needs and resources in the community. Many health problems require a continuum of services: progressive or regressive patient care, as the case may be, should not stop at the gate of the hospital but be allowed to extend freely beyond it. While McKeown's balanced hospital community is designed to provide complementary hospital services "for all classes of patients" (*3*), the broader concept of progressive patient care envisages centres combining not only hospital facilities but also doctors' surgeries for the care of ambulatory patients, housing for the aged, offices for public and voluntary health agencies, and personnel and equipment for the home care of patients (*4*). Resolution (77)3 of the Council of Europe conceives of the hospital as providing comprehensive care to both inpatients and outpatients.

It is in countries with a substantial private health care sector that, because of the lack of direction, the greatest fragmentation of primary care services may be expected, but the existence of a public health service is no guarantee that the services will be organized in the most desirable way. Nevertheless, where a substantial public sector health service—as distinct from health insurance—has existed, as in the

Scandinavian and later in the eastern European countries and the United Kingdom, there has been a greater tendency towards organized forms of primary care than in other European countries. By 1975 it could be observed that "throughout the world there is a growing emphasis on the establishment of health centres which aggregate physicians so that they can provide patient care in a comprehensive way utilizing the gains in medical technology and diagnostic aids, and with the support of a variety of health workers" (*5*).

In some countries, however, the collective practice of physicians was, and in some cases still is, hampered by legal restrictions or at least by concepts of professional ethics held by professional associations of physicians.

Three examples from diverse social systems may suffice to illustrate the worldwide recognition of the need for a better organization of primary care. In the USSR, the Tenth Five-Year Plan assigns particular importance "to the development of the network of units belonging to the polyclinic–outpatient system" (*6*). This implies the transformation of every ambulatory unit into a highly qualified prophylactic, diagnostic, and curative centre with the equipment and supporting services necessary to raise the efficiency of the district physician.

In the United States, with its pluralistic system, a Committee on the Costs of Medical Care recommended as early as 1932 "that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel" (*7*), a concept that has recently been broadened to that of the Health Maintenance Organization, which may assume a variety of organizational forms.

Like other less industrialized countries, India with its National Strategy for Health and National Health Scheme for Rural Areas aims at increasing the number of primary care centres and subcentres, adequately staffed and equipped (*8*).

A similarly wide range of social and health care systems exists within the European Region of WHO, and here too new forms of organizing primary care have developed and traditional forms have been adapted to meet the requirements of modern health services. Here too are countries with universal national health service systems and with pluralistic ones; here too are countries with substantially lower resources than those found in the more highly industrialized societies.

With such wide differences among countries in their socioeconomic–political fabric and their respective health services, can they benefit from the knowledge of the situation in other countries? Certainly countries with similar institutions can profitably examine one another's experience and, for the health services anywhere and for primary care in particular, some considerations are more or less universal. This is true of one of the basic requirements of primary care, i.e. accessibility, and it holds good for the basic component resources (personnel, equipment, facilities) and their availability and coordination.

Thus there are certain similarities in the structure of primary care

organizations everywhere, although the ways and means of organizing them may differ widely, as may their methods of financing and accountability, as well as the source of the incentive to organize, e.g. government, the medical profession, insurance carriers, or consumer groups. Where there is a public national health service, the government may decree (with varying degrees of consultation) forms of organization of primary care, as is the rule in the eastern European countries and the tendency in others such as, for example, Finland. This approach may also be encouraged where, as for instance in the United Kingdom, primary care physicians and dentists retain some degree of independence. Of primary care organization in New Zealand, it has been said that the primary care physicians themselves are alone responsible for the way they develop their service and that they are also the most appropriate people to develop it on a collective basis (*9*).

Where there is a national health service, a greater degree of standardization, though not necessarily uniformity, exists in the way primary care is organized, in contrast to the variety of public and independent private agencies found under pluralistic systems. The latter, on the other hand, with France and the Federal Republic of Germany as prominent examples, offer the advantage of a much greater variety of organizational forms, providing more opportunity for experimentation and study, an opportunity of which greater advantage should be taken. In countries with a national health service the health centre, as the hospital, is an integral part of the system and administered very much like other public utilities by the central or local government. In mixed systems, privately initiated and operated centre-like establishments frequently exist side by side with centres operated by municipalities or non-profit organizations such as religious or other charitable institutions. In the latter case, professional staff may be employed on a part-time or sessional basis while otherwise maintaining their private practice.

In any case, any form of organization implies bringing together several providers, types of service, and/or equipment. Depending on the objectives of a particular organizational form, it may emphasize a combination of different types of personnel (e.g. the primary care team consisting of physician, nurse, and social worker), or of personnel with similar functions (e.g. several general practitioners), or it may combine features of both forms by accommodating several primary care teams or by extending the concept of primary care to include certain specialties.

One may thus distinguish horizontal or vertical associations of health professionals, depending on whether they combine similar categories of personnel (e.g. general practitioners) or different ones (e.g. the primary care team, or general practitioners and specialists). Most frequently one finds combinations of these two forms. The reference above to specialties illustrates one of the difficulties in delineating primary care. Internists, paediatricians, gynaecologists and obstetricians, for instance, frequently appear as members of the primary care establishment; other specialties may be represented, particularly where there is direct access to specialists. In Canada and the United States it is the multispecialty

group that has been most strongly promoted: "groups of doctors with different skills, organized ideally, so that each ailment of each of their patients can have the care of an expert" (*10*). This must be seen, of course, in the context of a system of freely practising specialists as opposed to hospital employees.

The degree of standardization in the organization of primary care resources will vary according to the degree of socialization of the health care system. Standardization will be greatest where all health resources are owned, operated, and financed by one central agency, notably the state, and where all health workers are employees of that agency. Under these circumstances, primary care services are automatically an integrated part of the larger system and its organization. They are also apt to be organized within themselves, since all personnel and physical resources are administered under common auspices. One remaining problem may be that of an organizational framework to coordinate services provided by different government departments, such as health and personal social services where these are separately administered and financed. That central planning and a consequently greater degree of standardization do not mean uniformity has already been observed. Variations in the environment within a country will affect patterns of health and disease and, "the density of the population, its distribution over the area concerned, the state of the roads, transport facilities, communications, etc., play a large part in determining the forms of medical care provided" (*11*). Thus, for example, "a high population density may make it possible to set up curative and prophylactic, and sanitary and epidemiological, establishments that are larger in size and more economical and thus to increase the degree to which health establishments perform specialized functions; as far as medical personnel are concerned, this situation makes it possible for them to be distributed and utilized in a more rational manner".

These observations indicate the variety of criteria determining the optimal size of population covered by a health centre. Foremost among those criteria are population size, health status and demographic characteristics, the range of services provided, the availability of alternative sources of care, and the nature of the centre, i.e. whether oriented towards primary care or also specialist services of the kind available in the polyclinics. The issue is largely one of balancing accessibility with the objective of providing the desirable full range of primary care services and considerations of economies of scale. In an urban setting it seems that the optimal population base for a health centre, as the exclusive source of primary care, is about 20 000. The "učastok" model in the USSR is based on the community unit serviced by a physician in urban areas where, as in other eastern European countries, parallel streams of primary care exist. Thus the population covered by one physician ranges from about 1000 to 2000 for each of the therapeutic, paediatric, obstetric/gynaecological, and industrial "učastoks" (*11*). Thus, one of these units may serve a population of about 4000, whereas a polyclinic in one of the larger cities may cover a

population of up to about 50 000. While the Finnish system of health centres envisages units for populations between 10 000 and 15 000, this is based on a combined catchment area of from about 35 000 to 50 000 population, in which individual units would rely on the same laboratory and X-ray facilities.

The unifying force of central planning is absent in a pluralistic system—occasionally, with some exaggeration, referred to as a non-system—where at least a large part of the resources are in the private sector so that each hospital and every health professional may act as an individual agent. In this situation, any stimulus towards organization, i.e. integration of several components of the system, must come from the providers or consumers, either directly or through their elected representatives. An intermediate position exists where a substantial part of the financing of the services is through social security or insurance, in which case the carrier may offer incentives or impose conditions relating to organization.

Such pluralistic systems exist in the European Region. They have their counterparts in North America, and it is there that much of the research into the organization of care and its performance has been carried out. In many cases this will be applicable to similar phenomena elsewhere, though one major difference must be borne in mind, i.e. the difference in the relationships between doctors and hospitals. Another special feature of the North American scene is the combination of organized provision of services and financing mechanisms, i.e. the "prepaid group practice". This feature has relatively little relevance to the situation in Europe, where most countries have either substantial national health services or financing mechanisms covering at least substantial parts of their populations.

Health centres or similar organizations in many countries stress preventive services such as immunization, counselling, and maternal and child care. Especially if the centre is responsible for a defined population (defined geographically or as members/subscribers), it may have screening programmes and follow-up procedures, widely practised by "dispensaries" which function as ambulatory care facilities for patients with specific diseases such as tuberculosis or venereal disease. There are other elements of "outreach" aimed at high-risk groups. However, the concept of assuming responsibility not only for the care of the sick but also for the maintenance of optimal health in a given population is as yet limited to isolated experiments or demonstration projects. One of the early examples was that of the relatively short-lived Peckham Pioneer Health Centre in London. Even its creators looked on it as an experiment, based on broad biological principles rather than medical science in the conventional sense. It was labelled as an experiment in living, and the unit of living was seen not as the individual but the family. Living, in the view of the Centre's founders, meant health which, if not synonymous with life, was seen as "the factor of primary importance for human living" (*12*). Here, then, is an example of family orientation considered as an important attribute of health care, such

care being more than immunization and screening for disease which, while operating efficiently as a sieve for the detection of disease and disorder, "is ineffective as a health measure in the absence of 'instruments of health' providing conditions in and through which the biological potentiality of the family can find expression". The Centre, first established as a "family club" in 1926, took on its full family- and health-oriented approach in 1935, but owing to wartime disruption its activities were suspended in 1939. One condition for the successful functioning of an institution thus oriented is, of course, its whole-hearted acceptance by the population covered. It was concluded that, "given suitable circumstances, there were families who would welcome a Health Service distinct from any sickness service and without being urged by any sense of impending sickness". This statement may be found even more valid today, a generation later, when there is so much more emphasis on changing life-styles in order to preserve health. The Centre was revived after the Second World War but by 1951 had to be closed because the project was seen "to be contrary to the policy" of the Government, which by then had instituted a universal National Health Service.

Among services based on similar ideas were the Pholela Health Centre in South Africa (*13*) and the project carried out in the 1950s by the Montefiore Medical Group in New York (*14*). If Peckham was an experiment, Montefiore was a "demonstration" of family health maintenance. Both were strongly family-oriented, the former serving as a study ground for biologists, the latter emphasizing sociological aspects.

For the establishment of similar programmes elsewhere it may be as revealing to know why earlier experiments eventually failed, as it is to see the results of their studies. As regards the Peckham experiment, it was indicated very clearly why it could not survive as part of the recently established National Health Service in the United Kingdom. The reasons why it could be considered as "irregular" in such a service were stated as follows (*15*):

(1) It is concerned exclusively with the study and cultivation of health: not with the treatment of disease.

(2) It is based exclusively on the integrated family: not on the individual.

(3) It is based exclusively on a "locality": it has no "open" door.

(4) Its basis is contributory (2/- per week per family): not free.

(5) It is based on autonomous administration, and so does not conform to the lines of administration laid down by the Ministry.

Not all of these points would be seen as "irregular" today, if the principles of health maintenance and family orientation were to be adopted on a national scale. Peckham, at the time, had to be based locally and to be contributory and autonomous, because there was no alternative national service. But, even today, how many health services are prepared to aim at maintaining health as much as they are committed to the treatment of disease? How many are ready to accept the integrated family rather than the individual as the unit of care?

Immunizations produce quick and readily demonstrable results. They are also easily identifiable as applications of medical science and technology and therefore as appropriate functions of the health care agency responsible for the health of a given population. The promotion of healthy living, potentially more effective in the long run, is more difficult to specify in operational terms and hence more difficult to view as a function of the medical services. It is being attempted, however, as for instance in the North Karelia Project in Finland, where an intensive health education programme has been built into health centre activities (*16*). Elsewhere, as for example in Canada and the United Kingdom, governments have formally stated a policy of promoting healthy lifestyles among the population but as yet with little indication of how such a policy is to be made operational.

In concluding this general review of concepts of organized primary care, it may be well to point out that the component parts do not necessarily have to be under one roof and that a single building is not essential to the concept of a health centre. This is brought out very clearly in the recent establishment of a health centre system in Finland, and has been proposed as one solution to the fragmentation of a health care system as pluralistic as that of Canada, where services provided under a wide variety of auspices could be coordinated by a central agency (*17*). An early proposal for a health maintenance project in the United States described the concept as follows: "co-operative but not unified services were envisioned: nursing and social work from Community Service Society, out of their own offices; medical care from a medical group center in some other place—no single location for the combined services, no single unit for health and welfare services" (*14*). Such loosely knit coordinating arrangements will be partially effective where no coordination whatsoever exists as yet among agencies under different auspices, but they will fall short of bringing about integrated teamwork and the team approach to health problems.

In short, Hogarth's remark on the term "health centre" holds good: "a term which means different things in different countries, and may therefore require to be defined in the context of a particular discussion" (*2*).

Primary care and health policy

General health goals do not vary much, if at all, even among countries with widely different social and economic systems. All subscribe to the goal, set by WHO, of attaining the best possible health for their people, although countries do vary in the place assigned to health in the order of national priorities. There is a high degree of similarity in the human and physical resources used in different countries to attain health goals. Well trained health workers can, apart from language difficulties, function effectively in any country, as attested by their high mobility where there are no administrative barriers, and a good hospital is a good hospital anywhere. The availability and accessibility of these resources to the population they are to serve can readily be observed.

The often repeated statement that health systems, or certain of their features, cannot be transplanted is therefore at best of limited validity and applies mainly to the way the services are financed.

The question of the leverage a government requires to implement changes that may seem desirable is another matter. To what extent national or autonomous regional policy affects health policy and, in turn, its impact on the health services depends on the extent of the public sector's control over health resources. A greater degree of public funding and of direct public sponsorship will lead to a greater degree of standard-setting and control, though this will not necessarily be the same for all sectors of the health services. Hospitals have a longer tradition of being in the public sphere than has the practice of medicine. In all countries, the provision of hospitals has traditionally been accepted as a community responsibility, whether it is a public initiative or a non-profit private one, although not necessarily to the exclusion of private ownership. Some form of health insurance or social security coverage is more likely to be found for inpatient hospital care than for care outside the hospital. The practice of medicine, on the other hand, and that of the other health professions, particularly outside the hospital, is more likely than the hospital to be free from public control.

Independent practitioners will tend to organize their services to suit their needs and the needs of their patients as they perceive them. It follows that countries will display greater variation in the way that primary care is organized than in the manner in which their hospitals operate. It should thus be possible to develop a typology of organizational forms in primary care, according to the degree of public or quasi-public control. Four broad categories of primary care situation emerge:

- countries with a unified state health service system, where institutions are publicly owned and operated and all personnel are employees of the system (e.g., the eastern European countries);
- countries where most medical practitioners, at least those outside the hospitals, and other health professionals are independent (e.g. France, the Federal Republic of Germany and other central European countries);
- countries where health professionals are formally independent but bound by uniform contracts to the public system (e.g. the United Kingdom); and
- countries that would fall into one of the above three groups but present special problems because of their lack of resources compared with the more industrialized countries in the Region (e.g. some of the countries bordering the Mediterranean).

Such a classification has some merit because it shows at a glance the basic differences between unified, centrally planned and operated systems and pluralistic systems with only a limited public sector. The former, as expected, show a greater degree of standardization, whereas the latter

offer a greater variety of approach. For an analytic appraisal, however, this typology constitutes as misleading an oversimplification as do such other dichotomies as socialist/capitalist, eastern/western, developed/developing. Factors such as population density, rural–urban distribution of the population, climate and topography, communication and transport, the nature of the major health problems and, last but not least, the resources available will affect the way primary health care is organized, even within a given political structure.

Other typologies could be devised, for instance, on the basis of parallel situations within countries. For certain purposes it would be particularly useful to compare, for example, the provision of primary care in metropolitan, other urban, and rural areas within countries with different health systems. Comparisons of the provision of primary care in sparsely populated or isolated areas by countries in the North African part of the European Region and by countries extending into the sub-arctic or arctic zones might also be of interest. The latter were briefly considered by a WHO-sponsored conference in 1962 (*18*), but more intensive and up-to-date studies in these areas could be of considerable interest to the countries concerned. Ministries of health in all European countries agree on two points:

— that there is a need to strengthen primary care and relieve the hospital of demands that are better and possibly more economically satisfied elsewhere; and
— that primary care can accordingly no longer be adequately provided by the practitioner single-handed, but that supporting staff and facilities must be provided whose coordination requires some sort of organization.

Common to all types of centres or clinics is the idea of a combination of resource components. This may mean different categories of personnel working in close relationship with one another—the team—or increasing the effectiveness of the professionals by making various types of equipment readily available, in some cases even providing beds. The two forms usually go hand in hand, but the scope of the team and the extent to which it is supported by physical facilities vary considerably.

A policy involving organized forms of primary care on a national scale has been the rule in the eastern European countries for many years and what has been said of the German Democratic Republic (*19*) applies to other countries as well: "Polyclinics and the so-called ambulatoria are seen as the corner stones of socialist health protection in the DDR". The primary care teams in the rural ambulatoria and nurses' stations provide the link between population and physician.

While government policy may be equally oriented towards the health centre concept in countries where primary physicians are essentially in the private sector (though largely paid through public or semi-public insurance systems), the implementation of government policy is difficult

because physicians are generally free to practise as and where they like. There is some variation, however, in the extent to which the governments of these countries provide leadership and incentives. In countries with a federal constitution, there is the additional factor of responsibility for health and health services being primarily under regional jurisdiction, with the central government assuming at best a guiding role whose influence is largely determined by the size of its financial contribution.

The approaches adopted by governments of countries with a substantial private sector vary. In France, the social security agencies establish and operate polyclinics and centres of various kinds, mainly in major urban centres; these are linked with services in the private sector through a two-way referral system, especially for more sophisticated technical and specialist services. Finland emphasizes coverage of the rural areas in implementing its health centre programme, also maintaining links with the private sector, which in this case is relatively small. Scotland has promoted its policy by extra payment to practitioners working in groups, by direct reimbursement of rent, and partial but substantial reimbursement of the salaries of ancillary staff (*20*). Although similar incentives for collective practice exist in the other regions of the United Kingdom, practitioners there seem to have been more reluctant to work in health centres, initially under the auspices of the local authorities (*21*) and, since the 1974 reorganization, under the Area Health Authorities.

The Federal Republic of Germany introduced new incentives for the organized practice of primary care as one of the measures in its cost containment programme of 1977, echoing a renewed emphasis on health centres and similar forms of practice in a British Government document outlining priorities in the health and personal social services at a time of severe financial constraints. The stress on cost containment is a pervasive one. The Austrian Federal Ministry of Health and Environmental Protection has also declared its intention to lend material and ideological support to the idea of group practice, partly to counter the rising cost of hospitalization (*22*). Possible approaches to the implementation of this policy, based largely on experience in Austria itself and in other European countries with pluralistic systems, are discussed in a publication of the Austrian Federal Institute of Health (*23*). While the problem of cost containment lends urgency to the search for new approaches and may be the prime motive for political action in this sense, concomitant improvement of the services is not entirely lost from view. The chain of traditionally available services often leaves gaps inhibiting the continuity of care that patients require. Also, traditional services are essentially passive, i.e. they wait for the patient to consider himself in need of care, with the result that any prevention is largely relegated to its secondary stages (*24*). In countries where health services belong essentially to the private sector, there are quasi-public forms of organized primary care such as clinics operated by insurance carriers or the *mutuelles* in France, which operate for the benefit of their members

who carry the basic public insurance. A means of linking the various existing health and personal social services and, on the other hand, bridging the gap between the public and private sectors is provided in France by the Union nationale interfédérale des Œuvres et Organismes privés sanitaires et sociaux.

Countries with unified health systems under public auspices have clearly defined concepts and specific standards for their health centres at different levels. The provision of such centres to serve the entire population may, however, be hampered by limited resources, and in such cases priorities are established, usually in favour of the generally less well-served rural areas. The United Kingdom, for instance, in view of severe economic constraints, is prepared to compromise in regard to its standards for health centres by encouraging the adaptation of existing premises rather than waiting until funds become available for the construction of centres as envisaged at the creation of the National Health Service, and the government is considering even greater flexibility in the application of health centre policy (*25*).

Countries where general practice is largely in the hands of private practitioners are generally willing to support various forms of collective practice initiated by the physicians. In the Netherlands the Ministry of Health and Environmental Protection, also very much concerned with the effective organization of primary care, does not commit itself to any specific form of organization pending the development of ideas about primary health care through discussions of such basic questions as the content and scope of primary care, the respective roles of the public and private sectors, and the role of the population as the consumer of health care.

In all this, the boundaries of what constitutes primary care remain blurred where specialists are available in health centres (in some cases directly accessible to the patient) and where limited numbers of patients may be admitted to beds attached to the centre. Primary care, therefore, as indeed the health centre, must be seen and defined in the context of a particular health system. The three levels of care—primary, secondary, tertiary—may reflect increasing degrees of specialization or, as in the Netherlands for instance, depend on the place where care is provided, e.g. primary care being ambulant, extramural, or in the home; secondary care being given by specialists to out- or inpatients in general hospitals; tertiary care being generally provided in institutions for long-term care.

It is essential, therefore, to observe primary care, its organization, functions, and objectives in the context of the health system as a whole. To view it without regard to the provisions for secondary and tertiary care would be as unsatisfactory and narrow as attempting to understand hospitalization merely by studying patients between admission and discharge. Most people require care both inside and outside the hospital, at least at the extremes of their life span and frequently also in between. The systems approach is implicit in the concept of progressive patient care in its broadest sense, ranging from intensive to ambulatory and home care (*26*). In the light of the broad range and the continuum of

human need, it would be artificial to maintain a sharp dividing line between in- and outpatient care; these must not be considered as mutually exclusive alternatives but as stages in a process whereby "the choice of any particular type of medical care must be governed by the condition of the patient and by economic considerations" (*10*).

It is primarily the medical condition of the patient that determines the type of medical care he needs but his social condition also plays a part. Not only is the concept of medicine being extended to cover such behavioural "diseases" as the addictions, social disease in the narrower sense, and even delinquency, but there is growing recognition of the interrelationship between health and the social environment and between health services and the personal social services.

The Peckham and Montefiore projects mentioned earlier were directed towards positive and complete health. Some forms of integration or at least coordination of health and personal social services in selected European countries have been described by the WHO Regional Office for Europe (*27*). These may involve formal or informal arrangements for contact between the health and social services, or social service personnel may be actually attached to the primary health care team, the social service thus serving as an arm of the health service. That this relative position can be almost reversed is illustrated by the neighbourhood health centres established in the United States under the antipoverty programme. These centres, under the sponsorship of the Office of Economic Opportunity, address themselves very directly to the social problems of their communities. Thus, it has become one of their functions to provide employment opportunities, especially by training and employing the so-called neighbourhood health workers who are recruited from the population served by the centre. These workers provide simple medical, social, and preventive services and facilitate communication between the centre and the community (*28*). Another special feature of these centres, resulting from their broader role, is the high degree of community participation and often control. As a result, the health centre becomes a tool not only for providing medical care but also for the social and economic betterment of the community. Going even farther beyond traditional concepts of medical care, some see the effective organization and use of primary care as a possible means "toward bringing change in the socio-political structures which now prevent movement toward health" in its broadest sense (*29*). Generally, however, the immediate aims of health policy are stated as equitable distribution and optimal accessibility of health resources.

Because health services—and, most directly of all, primary care services—fill a universally recognized basic human need, they constitute a societal activity that, like certain public utilities, may be wholly or largely "socialized" even in otherwise "free-market" societies, which makes the international study and comparison of such services particularly pertinent. It is of interest, therefore, to compare the ways in which health centre policy, once adopted, is implemented. In some countries health centres are already part and parcel of the social and

political fabric; in others the policy is implemented gradually, and often very slowly; while yet other countries have not progressed beyond experimentation and statements of policy. Finland's approach merits attention as an example of policy, once adopted, being systematically implemented. Since Finland may be described as a pluralistic society, some of the features of its implementation of policy may have relevance to other pluralistic societies – bearing in mind, however, that in Finland, as in other Nordic countries, the provision of health services has traditionally been accepted as a societal task to a greater extent than in some central and western European countries. Subject to this proviso, Finland's experience with health policy provides a valuable case study.

The problems of Finland's health services over the last decade or so have been similar to those in many other countries: emphasis on hospital care to the neglect of primary care, including prevention and rehabilitation; the rising cost of hospital care; unequal distribution of existing primary care resources, both public and private; and lack of long-range planning on a population basis. Sickness insurance, introduced in 1964, alleviated the financial burden of sickness but did not improve the distribution of resources. Resources were needed also on the social service side to care for long-term patients, particularly the elderly. There was general agreement that the goal should be to improve primary care services, but there were conflicting views on how this should be achieved. There was the question of the respective roles of the local and regional authorities and that of the possible reactions of health professionals to the introduction of the team concept which would alter their traditional differentiated roles and relatively independent status (*30*).

The solution to these problems was the Public Health Act of 28 January 1972 incorporating the principle of centralized planning and decentralized administration, a principle that would have to be applied *mutatis mutandis* in constitutional frameworks of a federal nature. This Act made it possible "to coordinate the development within the national resource constraints through a centralized planning system" and at the same time to ensure that "the traditional local democracy and the independence of the local decision-making was maintained by the decentralization of the administration" (*30*). It should be added that local authority is upheld also through its participation in the national planning cycle and its share in the financing of health services. In introducing the bill, the government of the day stated the objective in now familiar terms: "to transfer the centre of gravity in our public health policy to health care and extramural medical care by creating the administrative and financial conditions for a rapid and organized development of the communal system of primary medical care"[a].

The problem of local autonomy versus central power is the ever-present one of the right balance between centralization and decentraliz-

[a] Government's General Argumentation, Public Health Act (No. 66) of 28 January 1972 (undated).

ation. In the case of primary care services, there is the added complication that primary health care, on the one hand, is attuned to local needs and relies on other local community services but, on the other, constitutes an integral tier (with secondary and tertiary services) of the regional or national health care system. The extent to which the financing of primary care services is the responsibility of the local community or is undertaken at a higher level also is an important factor in determining the respective authority and responsibility. These are among the political and administrative considerations determining primary health care policy.

There is also the human element, which is all-important, since the system can be fully effective only if it satisfies both the recipients and the providers of services. Where a system of health centres fills an earlier void, there will be little question of its being welcomed by the population served. Where it replaces existing services, any advantages of a new health centre may be recognized only after it has been in operation. Studies carried out in Sweden by the University of Uppsala and the Swedish Planning and Rationalization Institute of the Health and Social Services regarding the establishment of the Tierp centre and others have investigated these phenomena.

As for the providers, the replacement of traditional independent practice by health centres can prove very traumatic for them if it means not only changing the venue of practice but also altering general working conditions. The latter was the case in Finland following the Act of 1972. The role of the physicians, as well as their relatively high income compared with that of other health professionals, had given rise to some debate. The Act changed the status of health centre physicians in several ways, i.e. they were no longer accorded voting rights on the local boards of health, contracts for senior positions were given for 4 years only, and local councils were given power to dismiss a doctor even without consulting the National Board of Health. Concurrent legislation furthermore put doctors on a fixed salary based on a 37-hour working week, with extra pay for overtime (*31*). Paying health centre doctors by the same method as other health professionals also helps to put team members on a more equal footing and fosters a non-hierarchical relationship among them.

The loss of independent status in the new team approach, changing working conditions, and involvement in such managerial functions as planning and evaluation has created difficulties for some professional health workers, and the innovation has in some cases been perceived "as a danger to the professional status" (*30*). Nevertheless, the changes appear to be on the whole acceptable to the physicians, and the coverage of rural Finland by health centres has been progressing rapidly. With a population of 4.7 million, of whom about 3.4 million live in areas with less than 100 000 population, Finland had 269 health centres by the end of 1974 (*32*), fulfilling the objective of a health centre for every 10 000–15 000 population in the rural areas. As early as 1972/73, the health centres' share of all primary contacts had risen to 51 % in the southern and western areas of the country with their large urban

conglomerations, and to 66 % in northern and eastern areas (*30*). In the case study of policies for innovation just referred to, flexibility is stressed as "one of the most obvious features", being reflected in the gradual implementation of the new system subject to adjustments in the planning procedure as they occur. This flexibility is vividly illustrated by the fact that it is still possible to encounter an elderly rural general practitioner who prefers to practise in his old office, even though there is a modern health centre building only a few metres away obviously waiting for a new incumbent.

The report on the introduction of the new system (*30*) singles out the training programme as the most important technique of change, an opinion confirmed by those in the field. It is felt that younger physicians, more exposed to the tenets of social and community medicine, will be more ready than those of the older generation to practise in centres, a tendency also noted in other countries. The undergraduate education of all categories of personnel has been adapted to the new requirements. For those already occupying a position in the new system, training courses of several weeks are provided. The salaries of health centre personnel compare favourably with those of hospital staff.

The years of preparation for the new system provided ample time and opportunity for a full discussion of its objectives and implementation among politicians, administrators, and provider and user organizations.

Finland thus offers an example of the introduction on a national basis of a new system of primary care, albeit in a country with a long tradition of considerable societal responsibility for the health care of its population. Nevertheless, the change required broad acceptance by all concerned. There is still a strong private sector (though it is largely publicly financed), especially in the larger urban areas, where private health centres are to be found. A similar symbiosis of public and private health care organization can be observed in other European countries, notably (as already mentioned) in France, except that there the health centres under public auspices are concentrated in the large population centres.

A different situation exists where the maldistribution of resources is aggravated by their general shortage and the inability of large segments of the population to sustain needed services financially. Under such circumstances the state has to supplement the private sector by centrally provided and financed services similar to those found in the unified systems of the eastern European countries, except that the nationalized services are provided on a selective basis where the private sector fails. An example is the organization of *ocaks* (health centres) and health stations in Turkey, covering about a third of the country's population. However, maternal and child health centres are also operated by the government in areas not covered by the nationalized health services.

In short, it is apparent that countries in the European Region generally have accepted the desirability of the organization of primary

care in health centres of various kinds. The pros and cons of health centres will accordingly not be further discussed here, but reference can be made to the substantial literature on the subject. A report by the Council of Europe (*33*) summarizes the advantages and disadvantages of the related forms of group practice and health centres. But the report repeats the often voiced criticisms that health centre care is impersonal and detrimental to the desirable physician–patient relationship, that "the very idea of a family doctor is irrelevant", that "there are virtually no home visits", and that the appointment system generally practised in health centres may discourage immediate attention when needed. But surely these are not matters inherent in the nature of the health centre, and many centres exist where, for regular appointments, the patient can see his own physician, where there is no ban on home visits, and where provisions for walk-in patients ensure ready access. It has also been said that, where several physicians are involved in the care of a patient, none of them is apt to accept the basic responsibility and that "the individual doctor thus feels less committed to his patient" (*34*). This again is not necessarily an attribute of health centre practice and, in fact, shared judgement and responsibility may well benefit the patient.

It has been observed earlier that, in European countries with pluralistic systems, the problems of organizing primary care are much the same as they are in North America, where a good deal of research on the subject has been going on. One Canadian study of group practices (*35*) draws attention to the potential contribution of group practice organization to the regionalization of health services, an important consideration in the rationalization of hitherto largely unplanned health services. Policy considerations in many of the European countries are echoed in the way a report on health centres commissioned by the Canadian government summarizes the issue: "In summary, community health centres are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities, and relationships which society wishes to establish for health care in the future" (*36*).

Community interest in the development of the health centre model in the provision of primary care should be seen against the attitudes of those staffing the centres. For most categories of staff, a health centre represents a source of employment very much like that of the hospital. However, in health systems where the medical profession maintains an independent status with the ability to choose the working environment, the balance between the pros and cons of work in centres under public auspices will determine the success of such institutions. There is then, first of all, an ideological issue of working in the public versus the private sector. In either sector, the participating doctor in a health centre practice has the advantage of a regular schedule, usually with provision for holidays and time for continued education. There is ready professional contact with colleagues and often greater incentive and opportunity for research. Diagnostic and therapeutic equipment and

supporting staff are more likely to be available in a health centre than in single practice, and there is usually a more structured relationship with the hospital. Especially for the younger doctor, entering health centre practice eliminates the financial and logistic problems connected with establishing a new practice. On the other hand, while many, and especially younger, doctors welcome the opportunity for teamwork with colleagues and members of other professions, the more individualistically oriented will find it difficult to make the inevitable adjustments required. Impressions gained during medical education and training play a role here.

Organizational structures

The meaning of the term "health centre" or any of its variants must be understood on two levels: first as a physical facility accommodating the health team and its equipment, and second as an administrative concept encompassing any arrangement whereby a variety of services are integrated to provide comprehensive primary care; in the latter case, the component services may be at different locations and even under different auspices. It follows that the concept of a health centre as an integrating, or at least coordinating, agency will be particularly applicable in pluralistic systems where indeed various services may be provided under different auspices.

Even where each practitioner, institution, visiting nursing service, laboratory, and other agent or agency of health or personal social service has been working independently of the rest, it is possible to establish a coordinating centre with direct lines of communication to each of the practitioners and agencies concerned, so that all services existing in the community can readily be mobilized when needed. This could relieve the physician, for instance, from the need to maintain liaison with a multiplicity of agencies and he could refer patients for specific services—diagnostic, curative, or rehabilitative—to the co-ordinating centre just as he would refer them to a hospital for inpatient care (*17*).

Another version of this system is the *Anlaufstelle* in some communities in the Federal Republic of Germany. The United States concept of the Health Maintenance Organization also comprises not only group practices functioning under one roof, but also other forms of association among otherwise independently operating practitioners, with the aim of providing comprehensive services under a common plan of financing. One legal form taken by such an association may be that of a medical care foundation, sponsored by a local or state medical society with the objective of assisting member physicians towards providing quality care, and financed through private prepayment plans or categorical public plans.

Another situation in which the health centre concept is not confined to services provided from the same premises is when a health centre extends the geographical area it serves by establishing subcentres, often

themselves referred to as health centres although they are administered, supervised, and supported by the larger centre.

Thus, a health centre may be:

— a coordinating agency, which may or may not provide services to patients:
— an integrated system of primary care facilities comprising subcentres; or
— a facility where a variety of primary care services is provided under one roof.

While the last type is perhaps the one most frequently found in countries where the organization of primary care is left largely to the initiative of independent providers of care, or where there are no remote areas to be served by satellite centres, the existence of subcentres is found where a policy of regionalization of health services exists and where services have to be extended to outlying areas. But teamwork and coordination do not necessarily require a common physical base: "good premises do not necessarily produce good team-work, and a well integrated team can provide first rate primary care from accommodation which is inconvenient or unsuitable" (*37*). Whether first-rate care can be provided from unsuitable facilities may be questionable, and indeed the report just quoted goes on to say that, "other things being equal, the effective functioning of a team is likely to be promoted if it operates from a common base and is supported by adequate facilities"

Once again, the categories listed are not clear-cut ones into which primary care facilities can be readily fitted. One additional element for distinguishing among the various forms of centre is provided by the fact that there are centres or centre-like facilities that do not accommodate the complete primary care team or all the supporting activities available in the community.

Free-standing laboratories constitute an extreme example, perhaps altogether beyond the range of the health centre concept since they may not even provide direct services to patients or be directly accessible to them. They may, however, serve one or more health centres and possibly independent practitioners, thus constituting an essential adjunct to the primary care centre for all, or at least the more complex, laboratory procedures.

A similar relationship exists in what, in the Federal Republic of Germany, is called an *Apparategemeinschaft*, where physicians or groups of physicians use common diagnostic and therapeutic equipment, not necessarily situated in the same area as the users. Like a common laboratory, this arrangement reduces costs by pooling relatively expensive equipment, but it may entail additional travel for the patient to be examined or treated.

Inherent in the health centre concept, whatever its form, is the notion of a primary care team, generally including a physician. However, there are variations even on this theme, and there are centre-like organizations

that combine services by some, but not all, members of the team, in some cases even leaving out the physician. For example, the *Sozialstationen* (social service stations) in Rheinland-Pfalz, Federal Republic of Germany, provide a broad range of nursing and personal social services, including the loan of equipment, to ambulant and homebound patients, but not physician's services, although there is a physician on the executive committee. These services are provided, on referral, by a physician in the community. Like some health centres in Belgium and the Netherlands, these stations, are sponsored by religious organizations, in some cases on an ecumenical basis, i.e. sponsored jointly by both the Protestant and the Catholic churches in a community.

Another example of a centre-based team being supplemented by outside sources is to be found in the very frequent reliance of the primary medical team on personal social service resources available from other public or private agencies.

The degree of a health centre's dependence or independence varies fundamentally according to the health system of which it is a part. In a socialized system with strict regionalization, the primary care centre is a link in the hierarchical organization of the system with upward accountability and structured paths of referral and channels of consultation, combined in some situations with a horizontal relationship to the health committee of the local council. The extent and intensity of this relationship varies according to the local community's responsibility for the organization and especially the financing of primary care services within the area.

Under other systems this relationship will be transferred to whatever kind of sponsoring agency there may be, e.g. an insurance carrier, religious body, consumer group, or trade union.

Where, as for instance in Turkey and other southern European countries, the central government assumes complete responsibility for that part of the health system that is nationalized, lines of authority and accountability will be strictly from the centre to the periphery and vice versa.

Here again the dilemma of primary care makes itself felt, i.e. on the one hand its services are primarily directed to a more or less defined local population and it relies heavily on other local community services, but on the other hand it must remain integrated into the secondary and tertiary levels of the health system.

In countries with an independent medical profession, at least as far as primary care is concerned, the external relationships of a health or group practice established by practitioners themselves is analogous to those of single practitioners. Collective practices, however, sometimes have difficulty in obtaining payments from insurance agencies whose accounts may be with individual physicians only.

A health centre in a regionalized system may, in turn, assume authority over one or more subcentres. In all instances where health services must be provided for scattered populations in rural or remote

areas, health-centre-like institutions are found at several levels. In a socialized and regionalized system, these are highly standardized in regard to their services, staffing, equipment, and channels of referral and communication.

Such a hierarchy is clearly evident in the Finnish system of primary care centres with subcentres and dispensaries. Turkey has its *ocaks* and health stations. Eastern European countries utilizing the experience of the USSR have well defined steps in their organization of primary care, especially in rural areas, usually related to the size of the populations to be served. Thus, Bulgaria has "branch (village) polyclinics" for one or several areas with over 6000 inhabitants, a "village public health service" for areas with over 4600 inhabitants, a "village public health sector" for about 1500 to 4600 inhabitants, and a "medical assistant's health centre" for a population of about 500–2000. Hungary has its "central district physicians' office" for communities with more than one or two general practitioners, and its "physician's office" for one or two general practitioners in smaller communities. Romania has a hierarchy of "dispensaries" staffed and equipped according to population size. Similar gradations exist in other eastern European countries, especially where there is still a substantial agricultural population in the rural areas. Poland, for example, has its community centres, village centres, and clinics, particularly in the rural areas.

Also characteristic of the organizational structure of primary care in the eastern European countries are the parallel strands of general medical care, occupational or industrial health services, maternal and child health services, and *sanepid* (sanitary and epidemiological) stations. The respective categories of medical staff are variously referred to. For example in Czechoslovakia there are the "territorial health community physician" for the adult population who cannot use health services at their place of employment, the "factory health community physician" for those employed in industry, the "health community obstetrician–gynaecologist", and the "health community paediatrician" for children up to the age of 15 years. Dental services are provided by stomatologists. Depending on population size and corresponding staffing patterns, the different types of service may be accommodated in the same place or separately housed. For an adult employed person, the criterion for using either the general or the industrial health service is usually whether he is ambulant (in which case he would go to the industrial doctor) or not (in which case he would be cared for by the general physician).

A distinction must be made in socialized health systems between the strictly hierarchical relationship in all matters relating to management and administration, and the staff relationship, which also involves an element of supervision and surveillance but mainly takes the form of consultation, usually between the medical staff of the health centre and that of a more central polyclinic.

Arrangements for the transport of patients vary. Sometimes ambulances are attached to health centres, sometimes they are operated

on a regional basis. In countries with pluralistic systems they may be administered by such public agencies as the fire brigades, by voluntary nonprofit organizations, or by commercial enterprises.

In pluralistic systems, in which physicians are independent agents, there is an almost infinite range of organizational arrangements whereby physicians may be associated in their work. The pooling of laboratory services or equipment has been mentioned already. There may be formal or informal arrangements for substituting or deputizing. Physicians may establish themselves in a common building and share certain maintenance costs while keeping their medical practices strictly separate. They may pool office staff, equipment, and facilities such as reception desks, waiting-rooms, etc., they may form a loose partnership or a more structured group practice, or they may organize their practices in the form of a health centre with a central records system, pooled staff and equipment, and common accounting.

Policy regarding the inclusion in health centres of beds for inpatient care varies. Finland follows the principle of having beds (some for acute, some for chronic patients) in its health centres. Czechoslovakia, on the other hand, also as a matter of principle, has none. Elsewhere the practice varies; some centres maintain a few beds, mainly for observation. Others, like the Institut prophylactique in Paris, a voluntary nonprofit institution, maintain a hospital annex for short-stay patients.

The merits of having inpatient facilities attached to a health centre must be judged in the context of the particular centre and its function within the health care system. If there are to be beds incorporated in a centre, there arises the question of the kind of beds best suited to circumstances. The problems are due in part to the hitherto generally too rigid separation between outpatient and inpatient care, or the so-called community care versus institutional care, or simply the vertical and horizontal posture of the patient. There has been a movement towards integration from the institutional end by making the hospital the centre for the entire range of primary, secondary and even tertiary care. Thus, primary care centres or multispecialty clinics are located in the hospital or in physical proximity to it. This has the advantage of facilitating communications and of pooling capital investment in plant and equipment. A possible disadvantage is the effect on consumer acceptability because of the institutionalized and impersonal character of the entire facility and the impression it may create among some patients that they are "going to the hospital" rather than "just to see their doctor".

Until recently considerations of economies of size have led to increasing the bed capacity of general hospitals, which consequently served larger populations than would be covered by a primary care facility. The hospital also became farther and farther removed from the health centre, nursing station, or dispensary, thus making transport and communication more difficult. It meant furthermore that patients, in order to be hospitalized, had to be removed from their local community.

As a result, we witness the renaissance of the once shunned cottage hospital and/or the attachment of beds to a primary care facility. This provides a clue to the type of such beds. They would be either short-stay beds for diagnostic procedures, minor surgery and perhaps normal deliveries or, on the other hand, long-term beds for chronic patients requiring minimal nursing care and medical supervision but enabling the patient to retain his local ties.

One of the difficulties of attaching beds to a centre, rather than a centre to a hospital, is that in many situations the licensing provisions for inpatient facilities are such that staffing and building standards would very substantially raise the cost of building and operating the primary care facility. Another obstacle to combining primary care and inpatient facilities exists where the two operate under different auspices, e.g. public/private or national/local sponsorship and funding.

The degree of usefulness or appropriateness of a health centre incorporating beds depends also on the centre's location. Beds will be more useful where distance and transport difficulties render a transfer to a hospital difficult and risky, and where the patient would be removed from his social contacts and environment.

Since the term "health centre" covers a wide range of facilities—from the outlying post manned by an auxiliary, perhaps only once or twice a week, to the multispecialty polyclinic attached to a tertiary care hospital—there can be no general rule regarding the advisability of attached beds. But in a fully-fledged centre, serving a population of about 10 000 to 15 000, where round-the-clock staffing is available, beds for the specific purposes outlined above will be advantageous to both patients and providers of services.

Especially in countries where industrialization and urbanization are on the increase, there is a tendency to consolidate smaller centres and for several small communities to join in maintaining a common, larger, and better equipped centre. This tendency goes hand in hand with the consolidation of other community services such as schools and churches, and in Czechoslovakia, for instance, it has accompanied the trend towards combining agricultural cooperatives into larger units.

If any broad pattern emerges from the variety of organizational structures for health centres existing in the European Region, it is the distinction between socialized and pluralistic systems already noted. In the former, as a result of planned regionalization, there is a hierarchy of highly standardized types of health centre based on the size of the population served and staffed accordingly. Health centres in these countries are an integral part of the health system with clearly defined channels of authority, accountability, and referral. The health centres produced by pluralistic systems, on the other hand, are largely free-standing and vary widely in organizational structure. Since several governments have emphazised the need for further study of the problems of primary care organization, the experience available should prove most useful, especially in view of the current emphasis on the need for strengthening primary care services.

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2

Staffing patterns

Any organized form of primary care delivery is based on a mixed staff as well as the joint use of equipment, furnishings, and/or accommodation (*1*). Health services being labour-intensive, their main component and the factor determining their physical attributes is personnel.

The concept of "staff" used in the following description is a loose one. It should be interpreted in operational terms, i.e. what is available to the patient at the centre, rather than administratively, i.e. who is employed by the centre or by the agency operating it. It thus includes full- and part-time staff, as well as personnel attached or seconded, or even just available as required in special cases. As will be shown later, different categories, even of full-time permanent staff, may come under different administrative and budgetary jurisdictions.

Since health centres are essentially structures, organizational or physical, to accommodate primary care personnel, the staffing patterns vary as widely as the centres themselves and their functions. These patterns and the composition of the staff are determined by the following factors.

— First and foremost, there is the operational level of the primary care facility, which may range from a dispensary manned by one or more community health workers, with minimal diagnostic and pharmaceutical equipment, to a multispecialty polyclinic with sophisticated diagnostic, therapeutic, and rehabilitative equipment.
— The presence or lack of hospital beds for the centre is important since this determines the need for personnel for inpatient care.
— The centre's responsibility for transport, including ambulance services, will determine the need for personnel to man and maintain the relevant services.
— Whether or not other community services, including social services for patients, are administered under the auspices of the centre will likewise determine the need for the relevant categories of personnel.

On the other hand, there are situations in which personnel actually attached to and physically present at a centre are under the

administration of an authority at a higher level. This may sometimes be the case with respect to administrative and maintenance personnel as well as transport and ambulance personnel.

It would be futile, therefore, in this general review of primary health care in the European Region to attempt a description of the staffing patterns of individual institutions. Instead, the broad categories of personnel found in health centres will be indicated, together with certain major variations. The health centre concept reflects the progressive differentiation or growing division of labour in the health and allied professions. When, more than two hundred years ago, Adam Smith inquired into the nature and causes of the wealth of nations, he illustrated the increased productivity resulting from a division of labour in the production process by the well-known example of the pin: by dividing the process into about 18 distinct operations, a daily output of 4800 pins per worker could be achieved, whereas one worker by himself might finish one pin a day. Division of labour is associated with specialization, either as its cause or its effect. And what is true, according to Smith, of the trifling example of the pin is true of "every art and manufacture". However, essential for the achievement of the desired result, he points out, is not only the proper "division" but also the proper "combination" of the different operations (*2*).

Staffing patterns vary with the range and volume of services provided, the types of service being determined by the structure of the particular health care system and its underlying policy. The size and characteristics of the population served introduce additional variables.

On the other hand, the situation may sometimes be reversed so that the range of services depends on staffing patterns, i.e. when the size and composition of the staff are dictated not so much by the needs to be met as by the limited resources available for health care.

Where there are public health systems covering the entire population as, for instance, in the eastern European countries or where the public health system effectively covers the rural areas (for example, in Finland) there are certain staffing norms for institutions of the health centre type at various levels. Such norms lay down the *de jure* establishment, the *de facto* situation depending on the availability of the required personnel. In countries where the organization of services is left largely to the health professionals concerned, staffing patterns will to some extent reflect the needs of the population to be served but will very largely be based on personal considerations on the part of those involved in setting up the particular facilities.

It was stated earlier that the health centre concept implies some sort of team organization. The team phenomenon is further discussed in Chapter 3 of this report, but it should be emphasized here that the very concept of the health centre implies at least some range of multidisciplinary staffing and, at the same time, promotes the integration of staff activity. For the integration to be optimally effective, various other prerequisites must be met, but the implementation of the centre model provides a framework which stimulates cooperation and offers an

environment that facilitates communication and collaboration among the staff members. The common type of team in primary care is usually seen as comprising physician, nurse, and possibly social worker. This nuclear team can be extended by the inclusion of other professionals, such as psychologists, sanitarians, homemakers, technicians in various fields, members of such peripheral professions as teaching and the Church, and others who provide personal services. But the team may be seen from a somewhat different point of view. If the term is understood to mean the coordinated efforts of various professionals or services brought to bear on the same individual, then a concept of team and teamwork emerges that may include, for instance, the general practitioner, certain specialists, perhaps the general physician and the industrial physician in the eastern European countries, the personal physician, the radiologist, the pharmacist, or a variety of technicians, with perhaps only one of the team, such as the general practitioner, having actual contact with the patient.

It cannot even be said that a physician and a nurse (office or visiting nurse) would constitute a basic or minimal staff, because there are health centres headed by non-physicians—for example, some peripheral rural centres under the general supervision of a more centrally located physician—and the centres already briefly described which are available to a number of physicians in the community and to which a physician may refer patients.

Because of this wide variety of factors determining staff requirements in a primary care organization, the combinations of staff found in such organizations in Europe are almost infinite. It will be best, therefore, rather than attempting to describe these various forms, to give an overview of the range of professionals and services encountered. It will then be possible for the planner to determine whether a service not now available in a health centre should be added or, conversely, whether a service now provided should be abandoned.

The range of staff categories represented in the various types of health centre illustrates two points made earlier. First, the presence in what are essentially primary care or first-access facilities of specialists and even superspecialists, as well as the inclusion of beds, makes it difficult to draw a sharp line between these institutions, hospital outpatient departments and polyclinics, and inpatient or day-care facilities.

Second, staffing patterns often include personnel and services that closely relate the health services to other personal community services, thus extending the concept of health care into areas in which professional services are given by persons other than those trained in medical science or techniques. Social work is the most frequently encountered of these peripheral areas but a surprising variety of other disciplines are integrated into health centre work.

The diversity of disciplines represented in primary care facilities and the many different combinations of personnel make it difficult to give a systematic presentation of the staffing patterns. On the other hand, a

mere listing of the categories of personnel found will fail to convey even a general idea of their interaction.

The diagrammatic presentation in Fig. 1 may help although it is, like most categorizations, an oversimplification concealing overlaps and liable in some instances to lead to the arbitrary assignment of individual items to particular categories. Fig. 1 shows three broad categories of personnel, of which two comprise the formal health care system, the third being coopted from other disciplines or community services, in relation to progression from the simplest and most peripheral facility, usually found in the more remote rural areas, to a more central and more sophisticated facility. It illustrates the simple truth that, other factors (such as the resources available or the existence of alternative sources of care) being equal, the size of the staff and its diversification will increase as the facility widens its scope in terms of the population served. Diversification may mean the addition of clinical specialties or the addition of equipment and the staff to operate it.

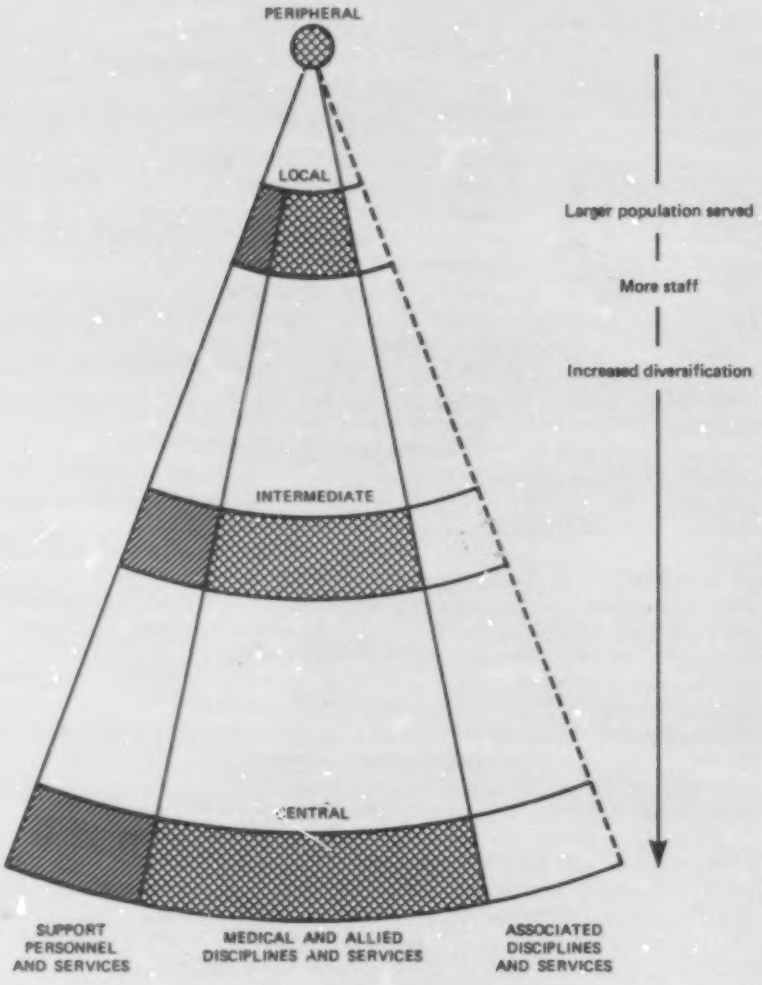
Central to any health care facility are those categories of staff who have received at least some structured training in a branch of medical science or technology, or in some medical skill. They range from the "barefoot doctor" type of peripheral staff to the superspecialist and include dental personnel, various categories of nursing and midwifery personnel, and various technicians and therapists.

As one proceeds from the peripheral facility (small health centre, dispensary, etc.) manned single-handed by a minimally trained professional to a more elaborate facility, a variety of support personnel are required, i.e. people trained in disciplines other than those mentioned in the preceding paragraph, but providing them with essential support and forming part and parcel of the health care establishment. They include secretarial and administrative staff, as well as maintenance personnel, drivers, and others. Their duties do not involve them in the direct care of the patient. Ambulance drivers with some special first aid training and certain technicians and therapists are on the borderline between this group and the preceding one.

A third group consists of personnel trained to provide personal services aimed at non-medical aspects of wellbeing but serving in various situations as members of the primary care team. They may do this on a full-time, part-time, or occasional basis, as required. Their services may either be financed under the appropriate health service budget or seconded by other agencies, on whose staff they remain. The most frequently encountered worker in this group is the social worker, but a surprising variety of others are found here and there such as, for instance, various categories of home help and professional personnel such as lawyers, clergymen, and marriage counsellors.

Also, as one proceeds from a minimally staffed peripheral facility to a more central one, the degree of specialization and diversity increases. Hand in hand with the increase in the size of the population or area served by the facility goes a general numerical increase in the number of personnel on the staff.

Fig. 1. The staffing pattern of health centres and clinics at different levels



The composition of the three broad categories of personnel, i.e. medical and allied disciplines and services, support personnel and services, and associated disciplines and services, is outlined briefly in the following sections.

Medical and allied disciplines and services

One essential feature of a primary care service being that it offers the first contact between patient and the health system, the most peripheral facility and its staffing are of great importance. As yet it is only here and there in the European Region that the postulate of Dr H. Mahler, Director-General of WHO, at the fifty-fifth session of the WHO Executive Board has been implemented, namely that "all health interventions should be undertaken at the most peripheral practicable level of health services by the worker most simply trained for this activity". Especially in health care systems with relatively low resources and in rural areas, the health worker with whom the first contact is made is not necessarily a general practitioner but probably a nurse or a person with more simple training, but enough to enable the health worker in question to perform certain interventions and to perform them adequately. If this adequacy of service can be ensured, then the employment of simply trained workers becomes not only a matter of economic expediency or efficiency but one of better or more effective care, since such a worker will be prepared to devote more attention and time to aspects of care for which the physician may have less time or interest, such as communicating with the patient.

What constitutes the most adequate training at a simple level can be determined only in the light of the activities or interventions to be undertaken, and for this a detailed knowledge of the specific tasks to be performed in primary care is required. The matter has been studied in a rural area of Hungary by the Medical University of Debrecen, in conjunction with medical institutions in Brazil and Egypt, under the sponsorship of WHO. The report on the study[a] stops short of a full investigation of the training implications of the tasks identified. Thus, for the time being, the most simply trained peripheral worker is still seen as a member of one of the traditional categories of health personnel such as sanitarians, feldshers, nurses, or community health workers.

Generally the staff increases in diversity and complexity of training as the scope of the centre is extended. This applies to each of the three strands shown in Fig. 1, but less to the associated disciplines for which it is mainly a matter of progressively intensive training. But in each strand the diversity extends not only vertically, i.e. with increased training, but also horizontally with greater variety of training, though at the same level, as in the case of specialists, technicians and therapists.

While in general the care team is directed by a physician, nurse, or other health professional, this is not always so. In the Federal Republic of Germany, for instance, there are the *Sozialstationen* (social stations)

[a] WHO unpublished document HMD/79.1, Geneva, 1979.

already mentioned, which operate without a physician on the staff and may be directed by social workers. This is the sort of institution that is available to several physicians in the community for their patients.

An interesting historical sidelight on the development of rural health care in pre-revolutionary France is found in a recent study of veterinary and rural medicine in that country (*3*). Veterinary medicine was well established, at least as a craft, in the predominantly agrarian France of the eighteenth century, whereas physicians were largely town-based. Gradually the latter also developed an interest in animal care in the countryside because of "the opportunity they saw to extend their controlling influence in medicine to the educational institutions, scope, and practice of rural health care". In this process veterinary medicine which had been developing steadily "was caught up in the global view of a unified medical science embraced by the physicians". Thus revolutionary medical care plans evolved from a concern with veterinary medicine and the desire to provide rural health care for both people and animals in the largely agrarian society of the time.

The community health worker

To begin with the most local categories of personnel, in some countries there is a category that has no medical training at all, but nevertheless provides personal services to patients. Workers in this category are not the same as those belonging to the group of supporting personnel. They are members of the community whose main function it is to maintain liaison between the population served and the formal health service system. They may be used to strengthen the system in underserved areas or to activate the "outreach" of a well-established system. In the former role, they fall into line with the proposal to the Twenty-eighth World Health Assembly that there should be a "selective development of a new tier of primary health care to underserved groups" (*4*). They may be said to provide a form of pre-primary care depending on their status *vis-à-vis* the formal health care system. An unpaid or volunteer community health worker is sometimes difficult to distinguish from the informal family-friend-neighbour network. On the other hand, they are akin to the "barefoot doctor" type of personnel who, with simple medical training, remain essentially part of the community rather than becoming members of the structured formal system. They may be entirely unpaid, receive compensation for expenses, or have a salary. There are two attitudes towards their remuneration. In some countries, especially those with full employment such as Poland, it is said to be increasingly difficult to find "volunteers" unless they are offered some remuneration for their services. Elsewhere it has been found that unpaid volunteers are difficult to hold to a certain schedule, because of the lack of a structured commitment. Then there is the situation, exemplified by the health programmes of the Office of Economic Opportunity in the United States, whose avowed purpose it is to provide, in addition to health services, employment in areas with high

unemployment. In some countries economic constraints on the health services have brought about a shift of emphasis from the hospital to the community at large so that a wide range of community services are required, including those of volunteers. The voluntary efforts of individuals, largely unremunerated, must be distinguished from those of voluntary, i.e. private, organizations whose field workers may be paid or unpaid. In the United Kingdom, a committee set up to inquire into the role of such organizations was told by the Society of Local Authority Chief Executives that "it is possible that there may be a new relationship between the two sectors (i.e. public and private) in which the statutory bodies will be saying in effect, 'This is all we can do with our resources and the rest is up to you.'" (*5*). This would simply mean a transfer from the public to the private sector, but probably with the implication that unpaid or underpaid volunteer work would supplement the statutory services.

Volunteer lay workers do, in some cases, receive a certain amount of preparation, if not formal training. In the Finnish province of North Karelia, for instance, a few hours of preparation enable a worker to maintain the necessary liaison between a health centre and groups of patients with certain chronic conditions.

The work of health centre personnel with structured groups of patients and the application of group therapy enlarge the centre's scope and widen its staffing requirements. Kulčar et al. (*6*) have described group work of this kind in Croatia. They list the chronic conditions for which the method may be applicable, the necessary activities and their duration, and the health centre personnel involved. In the majority of groups, work with the patient's family or work on social problems is also indicated.

These developments are of interest in the context not only of the therapeutic functions of the primary care centre, but of the extension of "outreach" functions into the area of health maintenance and prevention and the increasing emphasis on people's responsibility for their own health, thus in a way harking back to the philosophy behind the early Peckham experiment. They form part of the "people-helping-people" process which consists in supplementing professional resources through the use of various professional and semi-professional volunteers (*7*).

The rather amorphous area of minimally trained or untrained personnel, ranging from paid staff to unpaid community volunteers, is mentioned here because of the trend towards a greater community orientation of health services and a greater health orientation of the community itself. This will lead to new and different demands on the primary care facility and affect its staffing, as it calls for more than the traditional categories of health personnel. In particular, new approaches to the training and employment conditions of this group of "outreach" personnel will be required. As mentioned in connexion with group therapy, greater attention will have to be paid to family patterns of health and illness, as well as to environmental factors and lifestyles.

While the conventional tasks of the health services in terms of

diagnosing and treating illness are clearly understood, the new approaches to the continuing care of long-term illness, to prevention, and to health maintenance need more study in order to determine how best (i.e. most effectively and efficiently) the primary care facility can deal with these matters and what the implications are for staffing. The wide variety of existing arrangements should provide fertile ground for the study and evaluation of different approaches.

The traditional categories of medical and allied personnel at health centres are better understood and less needs to be said about them. As regards nurses, midwives, technicians, therapists and others, however, a clear distinction is not always made between those who are fully trained and assistants or auxiliaries. Nor is it always clear whether the latter have any formal training at all or receive whatever training they have on the job.

Those on the job, as well as the community health workers discussed above, probably come under what WHO terms "basic level" personnel in terms of training, the other levels being "middle" and "high". Under these three headings, WHO lists 25 categories of personnel, the last, however, being a residual group containing "other scientific and professional personnel", for instance psychologists and nutritionists (*8*). A survey of educational programmes for health personnel in the United States lists 154 types of "allied" health personnel who "supplement the activities of physicians, dentists, and registered nurses". All have completed a formal educational programme at one of the following levels: degree, diploma, occupational/vocational certificate, collegiate certificate, certificate of advanced standing, or continuing education certificate (*9*). At the international level, this differentiation of occupations leads to often considerable variations in terms and definitions, aggravated by idiosyncracies of translation. Subject to this proviso, the following discussion of staff found in health centres will give at least a general picture of the range of personnel employed. Among the reasons given for the Finnish legislation introducing health centres is that these centres would be better adapted than traditional medical practice for the introduction of new types of personnel. Just what types will depend, apart from the availability of resources, on the level at which a particular facility operates where health centres are the result of central planning, since only there it is possible to institute carefully instrumented and differentiated services meeting specific requirements in regard to quality, quantity, complexity, and continuity (*10*).

Reference was made above to the "barefoot doctor" type of health workers. As their tasks, training, and relationship to the formal health service system vary so much, it is difficult to find suitable terms to describe their function in any particular setting. A WHO Expert Committee has accordingly recommended that national or local names be sought for this category of personnel, avoiding such words as "auxiliary" or "ancillary" (*11*).

Typical of the confusing terminology and classification regarding health personnel other than physicians and perhaps nurses is the

situation in the British National Health Service. First, there is the distinction between professions and other occupational categories. Where the term "profession" is used, it usually denotes graduation from a university or a course of training equivalent to university training in terms of duration and level of training. In the United Kingdom, however, statutory regulations have in the course of time led to the identification of eight "professions supplementary to medicine", i.e. chiropody, dietetics, medical laboratory technology, occupational therapy, orthoptics, physiotherapy, radiography, and remedial gymnastics. These and others are variously referred to as professions or occupations auxiliary, supplementary, or complementary to medicine, and in the United Kingdom they include some twenty categories of personnel ranging from pharmacists and chaplains to helpers. There is also a residual category of "others". This heterogeneity is a result of rapid technological development and the continuous process of professionalization (*12*), which renders it difficult for personnel administrations and professional organizations to bring standards regularly up to date.

Physicians

Although a patient's first contact may be with one of the "outreach" workers described above or, which is more usual, with a feldsher-type worker, nurse, or some other public health worker manning a peripheral facility or subcentre, the central figure in the provision of primary care remains the physician to whom patients are referred or who directs the work or delegates it to other professionals.

Is there, then, such a thing then as "the" physician? There is to the extent that physicians comply with the WHO definition by being graduates of an appropriate "high level" school providing training that, in terms of content and duration, is standardized throughout countries to a high degree. To that extent then a physician is a physician is a physician, by the criterion that, wherever he is found, he will have the same sort of qualifications. Within this group, however, the types of physicians staffing primary care centres differ considerably.

There are the overlapping categories of primary care physician, generalist, and specialist, any or all of whom may be among health centre staff. The primary care physician is usually the physician of first contact, i.e. he can be approached without referral. The customary alternatives here are the general practitioner or family physician, the paediatrician, the gynaecologist–obstetrician and, especially in the eastern European countries, the industrial or occupational physician. Certain other specialists may also be directly accessible. Translation problems again complicate matters, but especially in the eastern European countries the industrial physician and the community physician have important roles in primary care, the latter being the one who looks after the general population including, under certain

circumstances, the industrial employees normally under the care of the industrial physician.

Among generalists, there is the traditional general practitioner, i.e. a physician without specialized training and, more recently, the specialist in general or family practice or community physician (not to be confused with the "district community physician" or "specialist in community medicine" who, as the terms are used in the British National Health Service, is primarily part of the administrative and managerial structure, whereas the Scandinavian district medical officer primarily provides direct patient care). From observation of general practitioners in various countries and settings, it appears that family orientation, attention to prevention and continuing care, and research as well as "outreach" are often practised as much, or even more so, by the old fashioned general practitioner as by his specialty-trained colleague in a glittering modern centre, these things being as much matters of motivation as of formal training.

While in some countries such as the Scandinavian countries and the United Kingdom the health centre concept applies to primary care in the narrower sense, i.e. the care provided or directed by the general practitioner and his dental counterpart, elsewhere the concept is extended to include some of the above-mentioned specialties considered as primary. Some countries maintain multispecialty centres of the polyclinic kind with increasing diversification the farther one moves away from the periphery to the medical centre; these offer both primary care services and a wide range of specialties. Direct accessibility to specialties varies according to the country and the specialty. These sophisticated polyclinics may be free-standing or attached to a hospital.

In universal public health service systems, the specialties to be represented at the various levels and the number of specialists in each in relation to the population served are subject to norms or guidelines. Where a substantial private sector exists, the numbers and combinations of specialists in centres established by or for physicians in this sector are determined by the views of those organizing the centre, the availability of congenial colleagues, and their perception of the need and demand for care of the population—usually ill-defined—using the facility.

An approach to bridging the gap between the public and private sectors is offered by the Centre diagnostic et des Soins de la Caisse primaire d'Assurance maladie for the Paris region. This centre is staffed by 7 generalists (a general practitioner and internists), 9 radiologists, and 56 other specialists representing 24 specialties including acupuncture (which, incidentally, is also prominent in other centres in the Paris region). This facility, including its extensive laboratory services, is used directly by the insured but also serves as a referral centre for private physicians and dispensaries. Also in the Paris region, however, there are institutions under private auspices, such as the Institut prophylactique, which also act as referral centres for physicians in the area. Although offering fewer specialty services, this centre maintains some beds for

short-term (usually 3–5 days) inpatients for diagnosis, observation, and treatment. It, too, has an elaborate acupuncture section.

Where polyclinics function as first-access facilities, they employ primary physicians as well as various specialists, some of whom may also be accessible without prior referral. These clinics offer teams in a broader sense. In the Bulgarian health services, the teams are described as "brigades" and as a rule include paediatricians, a neurologist, a surgeon, an ophthalmologist, an obstetrician, an otorhinolaryngologist, and a dermatologist–venerologist, as well as generalists.

The staffing patterns of health centres, then, are determined largely by the extent of central authority and planning. A curious halfway house between centrally determined norms and private initiative is to be found in the British system, in which the principle of health centres is laid down in the statutes but the actual establishment of a centre is guided in part by the number of general practitioners and dentists who give a prior commitment to work in the centre. As regards the status of the general practitioner and his relationship to the health centre concept, the British National Health Service represents a stage between the fully socialized systems, in which all facilities are owned and operated by the public authority and all health workers are employed by it, and those systems in which doctors, and particularly primary physicians, are independent agents in the private sector. In the United Kingdom, hospital doctors are employed by the public authority, whereas general practitioners, through their organization, contract their services to the National Health Service. They are thus generally free to practise where and how they want. Health centres in the United Kingdom, however, are built and operated under the auspices of the public Area Health Authority and there is a reluctance among some general practitioners to work in a centre lest they be subject to what they would consider undue control by the authority. Professional organizations are proposing, therefore, that health centres be owned not by the public authority but by an independent non-political body which would negotiate agreements with general practitioners wishing to practise from them (*13*).

Parallel with the mainstream of primary medical care goes that of dental care, which is offered in most health centres, except the most remote. Mostly located in the same facility as the medical services, dental services invariably form a separate entity within a centre. There are also free-standing dental centres, such as the *cliniques dentaires* in Paris, which serve mainly low income groups. In most countries dentists or stomatologists have a training corresponding in duration to that of physicians. This applies to the *chirurgiens dentistes* or stomatologists in France, for example, where *dentistes* form a lesser group who do more technical work and are now gradually being phased out. The *cliniques dentaires* in France cater mainly to children, and some have paediatricians and laryngologists on the staff. Psychiatric primary care likewise is generally offered by a distinct unit, often housed separately from general medical care services, except in some of the larger polyclinic-type facilities.

Dental care is generally accepted as an essential, albeit separate, part of primary care. Where health centres exist as part of a public care system, provision is made for dental care, subject to limitations of resources and restrictions in statutory entitlement to public dental care (e.g. restriction to children or other vulnerable groups). Dental care and dental staff may be consolidated in more central facilities where this is warranted by the size of the population served and the structure of the centre. Although there is a general commitment to the need for dental services within the primary care setting, its implementation is hampered where resources are scarce and where there is a shortage of dental manpower and equipment. In systems belonging predominantly to the private sector, where the public sector's function is largely confined to supplementing the system, there are free-standing dental clinics unattached to any primary care centre. The reason is obviously that, especially among poorer people, dental care is considered much more optional than general health care. Being insured under a social security programme, people are more likely to consult a physician than to take their children to a dentist, especially for prophylactic care. Examples of such free-standing facilities are the nine dental clinics in the Paris region, which operate under the auspices of the social security system. These are intended mainly to serve children and other vulnerable groups in low income areas. L'Institut de Prophylaxie dentaire infantile in Paris has a staff of dentists (stomatologists), working on a sessional basis and distributed as follows: 49 *chirurgiens-dentistes*, 5 *spécialistes qualifiés*, a *chirurgien-dentiste spécialisé en radiologie*, 2 *docteurs en chirurgie dentaire*, and a *rééducateur orthophoniste*. The Centre médical de la Mutuelle général de l'Education nationale in Paris, which offers its members a wide variety of specialty services (again including acupuncture), has among its 14 *chirurgiens dentistes* two specialists in dentofacial orthopaedics. In all countries, health centres that provide dental services have each at least one fully trained dentist or stomatologist on a full-time or part-time basis.

Nurses

The nurse is invariably considered one of the basic partners in the primary care team. The qualifications of the nurse, however, are less standardized from country to country than those of physicians or dentists. While WHO defines the professional nurse in much the same way as it defines the physician, i.e. as a graduate of an appropriate school, there is less uniformity among nursing schools and their curricula than there is among medical schools. Thus the EEC, for instance, could agree fairly readily on the reciprocity of the qualifications of physicians from member countries, whereas a corresponding step for nurses proved more difficult. Assistant or auxiliary nurses and nursing aides are less precisely defined by WHO. Midwifery too overlaps with the above categories. As a consequence, the population ratios shown in the WHO statistics refer to the rather heterogeneous groups of

"nursing personnel" or "nursing and midwifery personnel". Caution is accordingly needed when interpreting reported staffing patterns for nursing personnel, and for certain categories of technical and other medical personnel in health centres in such a variety of countries as those in the European Region of WHO.

In 1975 a WHO working group (*14*) concluded "that countries were at various stages of development with regard to primary health care services and no single pattern could be considered to apply on a region-wide or even multinational basis". Certain types of nursing can, however, be distinguished in connexion with health centres.

Where staff resources permit the diversification of nurses' functions, these may be viewed from two angles. One is that of the venue of the nurse's activities, i.e. whether at the centre itself or in the community. The other is that of the content of the activity, i.e. the nature of the particular service to which the nurse is assigned, such as general care, maternal and child care, industrial health care, school health, or preventive public health care.

The task of the nurse working in the community may be primarily preventive (Hungarians speak of the "protective" nurse) or it may be directed towards individual patient care in the home.

Specialized activities of nurses follow the prevailing pattern of services in particular centres. The practice of midwifery is sometimes combined with nursing, sometimes assigned to personnel trained in midwifery only. In addition to general nurses, the Scottish health centre organization provides for health visitors, district nursing sisters, midwives, and a nursing officer coordinating the nursing team.

In the health centres of Czechoslovakia, nurses perform some limited midwifery duties (since practically all deliveries occur in hospital). Specific categories include the health community nurse, the health community children's nurse, the dental nurse or assistant, the health community women's nurse, and the geriatric nurse.

Inpatient nursing is provided where beds for inpatient care are attached to a health centre.

Administratively, nursing personnel are usually part of health centre staff, especially where health centres are designed as such rather than as partnerships or group practices. This is distinct from arrangements like secondment or attachment in which the nurse remains the employee of an agency other than the centre. The first alternative is becoming increasingly predominant. Thus a report from New Zealand (*15*) recommended that the relevant authorities, while continuing the secondment of practice nurses from hospital boards, should be guided in staffing by the concept of the health centre nurse.

The level of training of nursing and midwifery personnel in different countries and in different situations within a country is difficult to relate to an internationally comparable standard and, until a special study of the subject is undertaken, it will be necessary to accept the different terminologies used by the various health administrations. WHO distinguishes high, middle, and basic level personnel. The high level or

professional nurses are those who are graduates of a nursing school and "qualified and authorized to provide the most responsible and competent professional nursing service" (*8*). But even within this category many countries distinguish between two levels: those referred to in the United Kingdom as the "registered" nurse and as the "enrolled" nurse. The criteria for the auxiliary (middle level) nurse and the nursing aide (basic level) are nursing supervision and the performance of less complex or non-technical tasks, respectively. In the *Sozialstationen* in the Federal Republic of Germany, the categories of *Krankenschwester*, *Krankenpfleger*, *Altenpfleger*, and *Familienpfleger* occur, representing different levels of training as well as different functions.

Training levels are not always so clearly distinguished, however, so that it is difficult in some circumstances to draw a hard and fast dividing line between workers with lower level nursing training and the various community health workers referred to earlier in this section.

Beyond the nuclear team: other health workers

The nuclear medical team, consisting of doctor and nurse/midwife is, except at very small peripheral stations, usually supported by some clerical personnel, such as a secretary. This will be further discussed in the context of non-medical support personnel.

Dental care, especially for children, has been mentioned as a generally accepted adjunct to the primary care services. And where there are dentists, there are some or all of the relevant supporting personnel, i.e. dental nurses or hygienists, dental assistants, or dental technicians, depending on the type and amount of laboratory work performed at the centre itself. Specialty centres such as those of L'Institut de Prophylaxie dentaire infantile have a very substantial laboratory service supported by a central laboratory for dental prostheses. The training and use of dental auxiliary personnel in the European Region are described in *Public Health in Europe*, No. 7 (*16*).

There is a clear trend towards greater attention to rehabilitation, which is particularly noticeable in countries where there is a centrally planned and operated national network of health centres. This is not invariably so, however, and the Belgian Ministry of Public Health and Family Affairs, for example, emphasizes that wherever there is a health centre it should employ a *kinésiste*. Physiotherapists are probably the staff most frequently added to the basic health centre team, and the necessary facilities and equipment for physiotherapy are accordingly often provided, even in relatively small rural or semi-rural centres. In a number of the centres visited, plans for the addition of such equipment were pointed out, as were plans for the addition of dental facilities. At a further level of development, physiotherapy becomes more specialized with the addition of occupational or ergotherapists, speech therapists, and others. The growing importance and professional stature of such personnel are illustrated by the fact that in Australia, for example, physiotherapists are now recognized as "first contact practitioners", i.e.

they can treat patients without referral by a physician, although most patients apparently still consult their physician first (*17*).

The addition of pharmacists to the team in centrally planned systems is largely a matter of the size of the centre, i.e. whether the demand exceeds what a physician could effectively handle. This entails the installation of a central pharmacy in the centre.

Dieticians or nutritionists are generally found in centres in countries or areas where undernutrition is a problem, especially among mothers and children. Turkey provides for a dietician in every maternal and child care centre operated by the national health service. Dieticians may have consultations with individual patients, but in general they are responsible for group education and training in nutrition of nurses and other health centre staff who in turn advise patients. In some countries the employment of dieticians/nutritionists is geared to local need and demand, as for example in Finland, where there is special emphasis on nutrition in connexion with the coronary heart disease programme in North Karelia.

Not so long ago people were advised not to take any chances with their health and to see a physician if they had the slightest doubt about it. That precept probably still holds good, but the emphasis now is on raising the threshold of doubt by persuading people to do more for their own health and by helping them to understand just what it is they can do. This is the task of health education, which reaches people through a variety of media, but in a more concentrated way through primary health care personnel in their direct contacts with the population they serve. Larger health centres and those where special preventive measures are needed, such as in the Finnish province of North Karelia with its high incidence of coronary heart disease, employ professional health educators. Their role is usually a dual one: first, to advise and instruct the other members of the team how to apply health education in their encounters with patients, and second, to work directly with population groups. The Scottish Home and Health Department (*18*) describes the responsibilities of health educators in health centres as "offering advice on suitable topics and how best to deal with them", and specifically as providing background material, advising on the use of health education equipment, training members of the primary care team, maintaining liaison with national health education agencies and links with national campaigns, and evaluating health education programmes.

Clinical psychologists are frequently found in connexion with child and youth services and as members of rehabilitation teams. Maternal and child care centres in Turkey include a psychologist or sociologist in the team, the latter also being found in some centres in Poland. Mental health centres in particular frequently have experts in fields relating to education; in the Netherlands specialists in educational science serve on the mental health care team, and they are also found in the facilities operated by the National Provident and Social Welfare Institute in Greece.

Chiropodists are found on primary care teams, especially for services

to the aged. Opticians are sometimes attached to health centres. Depending on the presence of X-ray or laboratory services, there are the corresponding technicians.

Where health centres deal with environmental health services, the relevant public health technicians, including veterinarians, public health inspectors and sanitary engineers, will be attached to the team.

Other health centre personnel with at least some elements of medical instruction include medical record librarians or card-index officers and ambulance staff.

Support personnel and services

Personnel in this group are mainly concerned with the internal organization and operation of health centres and of the services they provide. They do not concern themselves with patients' medical or social problems, and such contact as they may have with patients—as receptionists, cashiers, drivers, etc.—is of an administrative nature. They provide the support necessary to enable health professionals to work as effectively and efficiently as possible.

Their importance lies, however, not only in the necessary direct support, such as efficient record keeping, they provide to the health professionals but also in facilitating the external relationships of the centre with other parts of the health care system and other community agencies. To the extent that these personnel come in contact with the users of the centre, they play a vital and all too often underrated role in shaping the centre's image, its acceptability, and hence also the support given by the community. This applies particularly to the key position held by the receptionist, because it is here that the first contact between patient and centre is made and the first impression formed, a process which continues at subsequent visits.

The numbers and categories of support personnel, as of other staff, primarily depend on the size of the centre, on the existence of central norms and standards, and inevitably also on the resources available. Not all those serving a health centre are necessarily part of its staff from the administrative point of view: certain maintenance personnel, drivers, or administrative or clerical staff may be seconded to the centre by another agency—for instance, a department responsible for public buildings, a separate ambulance service, or a more central level of the health administration—and remain under its jurisdiction.

Categories of support personnel are described below. Some overlap with the medical disciplines will be noted, as in the case of the nurse/receptionist, the ambulance driver with rudimentary health training, and the medical record librarian as distinct from the filing clerk.

Office duties occupy various proportions of the working time of a variety of workers: nurse/receptionist, receptionist, secretary/telephonist, secretary or medical secretary, clerk, filing clerk, card index officer, or medical record librarian.

Among support staff, the receptionist occupies a position of importance in the relationship between patient and medical personnel. He or she is the first person met at the centre by the patient and also the one to make arrangements for subsequent encounters. The attitude of the receptionist may largely determine the patient's reaction to the centre and its use, and this may well affect the patient's behaviour respecting health or illness and his compliance with prescribed regimens.

That the role of a receptionist, at least as perceived by those using a centre, is not limited to the mechanical making of arrangements is illustrated by a Scottish study of patients' attitudes (*19*). It states that "most people thought that privacy at the reception point was important", and in Scotland people also found it adequately provided. At least at their first visit, patients may have to tell the receptionist something about their problems and the Scottish study suggests "that patients tend to discuss more confidential matters with the receptionists in primary care than they do with hospital out-patient receptionists".

The British National Health Service has a well structured category of "medical secretaries" and receptionists. The former are represented by the Association of Medical Secretaries, whose two-year training course is available at some 100 technical colleges throughout the country; the curriculum provides for attachment to teaching practices. Somewhat less structured is the training of receptionists, which is available under day or half-day release schemes or in full-time courses of 13–20 weeks duration. The Department of Health and Social Security has set up a working party to produce a training manual for receptionists and those engaged in other office work in primary care.

The functions of other clerical and administrative personnel, maintenance workers, and catering and housekeeping personnel (for example, at centres with inpatient facilities) are similar to those of such personnel in other institutions or organizations.

The role of the administrator, particularly the non-medical administrator, however, deserves some attention. In the health centre as in the hospital, increasingly complex organization has led to a need for administrative qualifications beyond those that can be expected of a physician/amateur administrator. The administration of a large centre demands a division of labour between staff and line functions such as exists in other complex organizations. In the health services, however, the staff has a relatively stronger role *vis-à-vis* the line administration than it has, for instance, in a manufacturing industry or even certain other service industries. In the health services, as in the personal social services and education, the output is on the staff side, leaving the line side with a more supportive role than it has in most industries. The report on a Canadian study of group practices (*20*) states that "most of the groups had decided that it was important to appoint business managers who would concern themselves with the day to day problems of ensuring group survival". This, of course, applies especially to independent groups of doctors in the private sector. In a government health service the administration of a health centre is more likely to be

part and parcel of the service organization as a whole, except perhaps in the case of the autonomous health institutions in Yugoslavia.

The functions of the administrator are described in a publication of the Scottish Home and Health Department (*18*). It states that non-medical administrators "have become firmly established as essential members of the staff of health centres". Their responsibility covers the management of the non-clinical services and clerical staff and is described as "involving the day to day duties needed to support the requirements of the professional staff". This concept of the administrator's function illustrates the earlier observation of the difference in staff and line roles between health services and industry. The administrator's specific duties are described in more detail on page 143 in the chapter on management and decision-making.

The Scottish report also stresses the importance of appointing the administrator some months prior to the opening of the centre because "there is much to be done in preparation for the receipt of equipment, furniture and supplies, in arranging for the transfer or appointment of non-professional staff and in preparing for the movement of practices and other services into the building".

Associated disciplines and services

Although the categories in this group are few, they are perhaps the most interesting. Their existence in the health centre structure illustrates the expansion of the concept of primary health care into one of primary care of the whole person and the indivisibility of human wellbeing. The disciplines they include are directed towards human service but not based on medical science or technology.

Psychiatry and psychology from the standpoint of medicine, and social work from that of social service, have been accepted as necessary bridges linking physical, mental, and social wellbeing. Social service has broadened in scope since its origin in welfare work aimed at the relief of poverty. If health means optimal functioning in the social environment, then spiritual adjustment is part of it too. The faith healer and the practitioner of traditional medicine are relevant here. Although both exist in the European Region, neither is reported as having any connexion with formal health care systems there.

Personal social work is probably the non-medical discipline most widely considered as an essential part of the health centre's functions. It can be safely said that it is seen everywhere as a necessary adjunct to, if not an integral part of, the work of the primary care team. The range of operational and administrative arrangements whereby health and social work are combined is a wide one.

Some countries—for example Poland—consider social welfare, providing for financial as well as non-financial needs of patients, as one of the basic tasks of primary care institutions, the social work being part of the nuclear team. For other countries, the integration of health and social services presents certain problems. In countries where both are

under public auspices, their administration and jurisdiction may lie at different levels, social services usually being the responsibility of the local authority while health services may be administered by the central government or at an intermediate regional level. Effective coordination is even more difficult where health personnel and the facilities they provide are in the private sector but the social service is a public institution. The *Sozialstationen* in the Federal Republic of Germany are examples of private, non-profit institutions intended to bridge the gap. In the public sector, in the absence of a national health service, individual communities may singly or jointly set up medicosocial centres. In France it is the Union nationale interfédérale des Œuvres et Organismes privés sanitaires et sociaux that seeks to bridge the gap between health and social services as well as between private and public agencies.

In most countries complaints about the shortage of fully trained social workers, i.e. with university-level training or the equivalent, are common. As a result, less well trained social service personnel are widely employed.

In some countries the functions of the social worker overlap with those of certain categories of nursing personnel such as the community nurse or, as in the United Kingdom, the health visitor. Either of these may be able to marshal other community services, such as home-help services, as required. On the other hand, certain functions carried out by the public personal social services in many countries may be performed by voluntary agencies and voluntary workers in others.

The Netherlands Ministry of Health and Environmental Protection mentions that pastoral care, administered by a clergyman as a member of the health care team, is in some instances considered as part of primary care. This may be related to the religious auspices under which some centres operate and a similar situation is found in other parts of the world. In Illinois, USA, a church-based family practice medical care facility, described as a "holistic health center", focuses on all aspects of an individual's health needs (*7*).

A similarly holistic interpretation of primary care needs has led, as in Belgium, to marriage and legal counsellors being considered as essential associates of the primary care team in certain urban districts. Indeed, it is not difficult to see a role for the lawyer in a programme dealing with the health problems and related social problems of patients and their families. The complexity of modern social security and assistance programmes and housing, employment, and family problems may well raise questions beyond the ability of the social worker to deal with. In such situations, personal legal advocacy could be helpful in maintaining or creating an environment in which medical care can become fully effective. In the Montefiore Neighborhood Medical Care Demonstration, mentioned in Chapter 1, two lawyers were employed by the centre, not to represent patients in their individual legal problems but to familiarize the staff with the legal problems that may be encountered by patients and to suggest solutions to such problems, or at least to draw attention

to procedures that might lead to solutions (*21*).

Sociologists are mentioned as possible team members in several countries, e.g. Poland and Turkey.

Some centres in Romania have kitchens for the preparation of infants' diets; these kitchens, like those for inpatients attached to a centre, require appropriate personnel.

The requirements for health-related education and social service vary according to the needs of the population served. Thus the Turkish Ministry of Health and Social Assistance has recognized the need for the instruction of young mothers in a variety of needed skills. Besides teaching subjects such as nutrition and food preparation, certain maternal and child health centres have dressmakers on their staff to give instruction in cutting and sewing garments; in some centres a special room is provided for this activity.

One category of personnel not specifically reported in any country of the European Region is the interpreter. Some informal provisions for interpreting no doubt exist in health centres serving different language groups; in such centres some of the personnel are likely to speak several languages and can help out. Recent migration, however, and the presence of guest workers in many European countries have rendered the clientele (and sometimes also the staff) of many primary care facilities cosmopolitan to the point where access and communications may be seriously impeded by language difficulties. In such situations the experience of institutions such as the New South Wales Health Care Interpreter Service in Australia (*22*) can be helpful. This service, launched late in 1977, supplies interpreters to a number of large metropolitan hospitals, health centres, and other community services such as family planning clinics. The plan is to extend the initial limited coverage throughout the State of New South Wales. The special training of the interpreters covers medical terminology, the mechanics of health care systems, the use and availability of other community services, the psychological and physical effects of migration, ways of establishing rapport with patients and health professionals, and ways of coping with crisis situations such as bereavement. The interpreter is seen as "a full member of the health team", as he could well be elsewhere, to the advantage of both clients and providers.

General comments

Statutory provisions and norms are not enough to make health centres fully operative. In regard to staffing, there are two more prerequisites to be met. One is a sufficient supply of personnel in the required categories; the next is the effective guidance of these health workers to the posts where they are needed. The first is dependent on resources as well as manpower planning; the second is also part of planning, but is equally a matter of directing or otherwise motivating individuals to work in certain places. A shortage of doctors will impede the development of health centres, as will the reluctance of physicians to work in health

centres where, as for instance in the United Kingdom, family doctors work within the system as independent contractors. Some countries have serious shortages of certain health workers. Turkey, for example, reported that only 40% of nursing positions in its health centre system were filled and that there was a 20–30% shortage of health technicians and midwives. Many countries share Finland's problem of recruiting and retaining sufficient physiotherapists.

All these factors combine to determine the staffing of individual primary care facilities. It also depends, of course, on the population served and on the alternative resources available to it. Where all resources are in the hands of a state-administered national health service and where this service is strictly regionalized, as in some of the eastern European countries, the staffing of individual centres follows national norms. Two examples from different systems will illustrate such norms.

Bulgaria provides an example of a highly structured, centrally administered, universal national health service with a regionalized distribution of health resources according to the "territorial-sector" principle. It is also still a largely agricultural country with the rural population forming a significant portion of the total population and playing an important role in the country's economy. Staffing norms and the structure of primary care facilities vary between the rural and urban areas. The rural health network consists of the following elements.

Branch (village) polyclinics, serving populations of over 6000. Depending on the size of the population served, the personnel of these clinics consists of 4 or 5 physicians, 2 or 3 stomatologists, maternity nurses, medical assistants, nurses, laboratory assistants, and assistants to the stomatologists. Twice weekly, each branch polyclinic is visited by specialists from the regional or district polyclinic.

The village public health service, serving populations of about 4600–6000. The staff consists of 2 or 3 physicians, 1 or 2 stomatologists, maternity nurses, medical assistants, and nurses.

The village public health sector, serving populations of about 1500–4600. The staff consists of a physician, a stomatologist, a maternity nurse, medical assistants, nurses, and auxiliary personnel.

The medical assistants' health centre, serving populations of about 500–2000. Staffed by medical assistants, it forms part of the structure of a larger facility.

The urban network consists of three sectors – the integrated therapeutic sector for the adult population of 15 years and over, the workshop therapeutic health sector in places of work, and the integrated paediatric sector for those under the age of 15. There are independent facilities for emergency medical aid. Polyclinics serving the three sectors are staffed according to the "brigade" method of work, embodying the team principle. The medical staff of a "brigade" consists of 4–6 "therapeutist" physicians, 4–6 paediatricians, a neurologist, a surgeon, an ophthalmologist, an obstetrician, an otorhinolaryngologist, and a dermatologist–venereologist, with the requisite supporting personnel.

These primary care facilities are associated with regional and district

centres with diversified and specialized staff.

While Bulgaria has a countrywide national health service, Turkey's national health service was designed primarily to cover rural areas that would otherwise be underserved, although it is intended to cover the whole country eventually. In the regions where services are nationalized, primary care facilities are staffed according to certain norms based on the size of the population served and the level of care provided. In the regions covered by the health service there are *ocaks*, or health centres, and health stations providing nurse-midwife services in the outlying areas.

In the *ocaks* staffing is as follows:

Urban: Type AI for populations of about 50 000

Medical personnel	*Support personnel*
3 physicians	3 secretaries
2 nurses	1 driver
4 health technicians	3 office aides
1 midwife	

Type DI for populations of about 20 000

Medical personnel	*Support personnel*
2 physicians	2 secretaries
1 nurse	1 driver
2 health technicians	2 office aides
1 midwife	

Rural: for populations of about 10 000

Medical personnel	*Support personnel*
1 physician	1 secretary
1 nurse	1 driver
1 health technician	1 office aide
1 midwife	

In addition, there is the midwifery staff in the health stations attached to the *ocaks*.

Different patterns exist in the maternal and child health facilities and in the health centres providing services for 10–25 inpatients.

More sensitive adjustments to basic norms and standards have been developed in the USSR; these allow for some measures of need or demand other than merely the size of the population. Popov (*23*) distinguishes between norms and standards, the former specifying needs in accordance with scientific findings, the latter—based on empirical findings—indicating the resources required to satisfy the needs.

For example, the number of medical personnel (other than dentists or stomatologists) for the outpatient establishments of rural *ucastok* hospitals is given by Popov as 0.25 per 1000 population; but if the

average number of consultations per person per year exceeds 1.5, then additional posts are provided for on a scale that depends on the size of the population covered. Similar criteria are applied to dentists or stomatologists. In other words, certain allowances are made for local conditions, such as the effects of the age composition of the population on the demand for services. Norms and standards "are intended for purposes of guidance only" and must be reviewed in the light of new developments such as the introduction of new techniques and equipment or the employment of other categories of personnel.

The existence of alternative sources of primary care will, as already noted, affect staffing needs in a particular facility. The balance between inpatient and outpatient care, public and private sources of care, and the presence of special clinics or dispensaries must be taken into account; in the USSR, for instance, 15% of the whole adult population attended by polyclinics received dispensary care in 1975 (*24*). Similarly, there may be facilities for special population groups (e.g. industrial employees, mothers and children) which will absorb some of the demand for primary care and thus influence staff requirements in a particular facility.

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3

The team

The staffing and equipment of a primary care facility require some degree of organization. At the very least this should be sufficient to enable each component part to function separately and in its own right. Several doctors' and dentists' offices, a pharmacy, and various laboratory facilities may be located in the same building with no more in common than the joint administration and financing of the building. As a further step, certain services may be pooled and arrangements made which may eventually result in some concerted approach to patient care. It is at this point that one can begin to speak of teamwork, a term that covers a wide range of interprofessional relationships, both formal and informal.

The personnel of a health centre are sometimes referred to as a team regardless of the degree of coordination. This does little more than describe a structure without any indication of its functioning. Here, it is helpful to follow Hogarth's suggestion (*1*) that "team" in the sense of a group of professionals be distinguished from "team practice" or "teamwork" meaning the method by which these professionals actually practice as a group.

To proceed from the structure of the team to the process of teamwork, a WHO Expert Committee (*2*) defined the latter as "a method of working towards a common goal which enables several persons to make the best use of their qualities by combining their skills and experience". A WHO conference (*3*) has defined team practice as "normally a medical practice further supported by a multidisciplinary team of paramedical professional workers such as nurses, midwives, social workers, etc.". While this definition mainly describes the composition of the team, a WHO working group (*4*) later broadened the concept, adding the criterion of being non-hierarchical, i.e. "a non-hierarchical association of people with different professional backgrounds but with a common objective, which in any given setting is to provide patients and families with the most comprehensive health care practicable".

The potential membership of the primary care team is demonstrated by the wide range of personnel found in European health centres. As for

the basic team, there is a general consensus that it contains a physician and a nurse. In the opinion of physicians consulted in a study in Yugoslavia (*5*) the minimum team should consist of: (*a*) in a village, a specialist in general medicine, a nurse, and a visiting nurse or a visiting midwife; (*b*) in a town, a general practitioner (not necessarily a specialist in general medicine), a nurse, and a multifunctional visiting nurse. The study also ascertained the preferences of the population served: these were for teams with at least three members, generally with university-level education, teams employing a specialist in general medicine, teams employing younger physicians, and teams including a visiting nurse or visiting midwife.

Because of the diversity of health centre personnel and their relationship to a particular centre—full-time, part-time, sessional, etc.—the composition of the team may well vary according to the population group served or even the individual case, reflecting Toffler's concept of the task-oriented "adhocracy" (*6*). Thus, for instance, team conferences in a children's centre in Honolulu may include the social worker in charge of the case, the social work supervisor, the medical director, the attending psychiatrist, a psychologist, a paediatric nurse, legal counsel from the Attorney General's office, and such others as may be invited (*7*). The Käpylä Rehabilitation Institute in Finland describes its teams as consisting of experts in different fields of rehabilitation, the composition and chairmanship of the teams varying with the character of a particular meeting; outside consultants may be included as required.

In the hospital setting, this task-oriented combination of knowledge and skills has been described as functional care (*8*) and this holds equally good in primary care. Services should not be provided in a compartmentalized fashion on the assembly-line principle but functionally, with each member of the team contributing to the collective effort through continuing consultation, regular exchange of information, common setting of objectives, division of labour, delegated task-setting, and monitoring.

This suggests limitations in the applicability of traditional organizational theory to health systems. It is true, of course, that the administration of a hospital or large health centre has much in common with that of a business organization. The difference, however, may be partly one between utilitarian and normative organizations – the former characterized by motivation for gain and increasing production, the latter by commitment to a set task (*9*), thus blurring the boundaries between staff and line functions or even reversing the two in the health centre setting, where it is the professional staff that does the work on the shop floor.

Teamwork is based on common objectives as well as common approaches towards these objectives. The mere presence of a variety of health professionals is not sufficient to establish teamwork: it is the "proper division and combination of their operations" from which the benefits of divided labour will be derived, as Adam Smith observed two hundred years ago (*10*).

The makings of the team

Some see the development of the team as a Hegelian type of dialectic process whereby the nursing and medical professions have attempted to resolve what is seen as their "conflicting drives" by progressive specialization, with the various forms of physician's assistant providing the synthesis. This theory, however, would not apply where the physician's assistant preceded the development of a highly specialized medical or nursing profession as in the case of the feldsher in the USSR. But it is not necessarily a matter of physicians and nurses being antithetical; there are other members of the team and developing types of service that are not necessarily conflicting but rather complementary, if effectively coordinated.

Teamwork is not based on the sharing of premises by all members but it is generally accepted that, as in the case of the Swedish model municipalities (*11*), as many as possible should be brought together in common centres. Warren (*12*) postulates that teamwork stems from a positive relationship between the morale of the team members and communication among them; morale, she concludes, determines the degree and quality of communication. Others may argue that a reverse causal relationship may also exist, i.e. that improved communication will raise the morale of the members of the team. There can be little doubt, however, that "personality conflicts arising from background contribute to team malfunctioning". Problems of morale or attitude, possibly traceable to the different backgrounds of team members, and their effect on communications are illustrated by a study in Northern Ireland (*13*). In the situation discussed, it was found that the medical staff made no use of the social workers' files even though these were available to them. The social workers, for their part, failed to indicate when no file was prepared or when it was kept at the social service office. While physicians and social workers usually saw eye to eye regarding the perception of facts, such as the history or circumstances of a case, they differed considerably in assessing the patient's personality and in their awareness of potential family or community support. Teamwork in this case was largely limited to mutual referral; such discussions as there were were usually initiated by the social worker.

The question of differences in background between team members will be further discussed later on, but some obstacles to a complete understanding among them may be expected simply from age and sex differences and widely varying levels of education and training. Medicine, for example, is still predominantly a male preserve in many countries, whereas nurses, social workers, and other health professionals are mostly women; physicians generally have undergone a longer academic education and professional training than members of the other health professions and, owing to the lack in many countries of social workers with full professional training, social work is often carried out by less well trained personnel; also, because of the physician's longer training, he is frequently older than his team-mates. All follow their own

courses of training, by and large in isolation from one another, so that when they meet in the work situation, they have little appreciation of one another's functions. Until exposure to, and appreciation of, teamwork is built into the respective training programmes, remedial action must be taken at the stage when members of the various professions find themselves faced with the need to collaborate rather than to command or obey or just work independently, each in his or her own narrow field.

In the health field proper the problem of true partnership and collaboration between doctors and nurses, particularly in the hospital setting, has always existed – and frequently been studied and documented. The addition of the social worker to the nuclear team creates a basically similar problem with an additional complication arising from the social worker's lack of any medical training. Thus, where problems of teamwork in primary care have been systematically studied, emphasis has usually been placed on coordination between the health and social services, a further difficulty often being that the two types of service may be administered and financed separately.

Sweden has been systematically evaluating and monitoring the functioning of its primary care centres, which combine health and social services. Stresses and strains within the newly created teams have received particular attention. The approach adopted at one of the centres is described as follows (*14*):

> In the initial phase, special interest has been devoted to charting the occupational roles of the different categories of staff employed by the care centre, and to an analysis of these roles in relation to each other. The object is to bridge the differences existing between the working methods of these groups, and their systems of reference, so that they can be included in a co-ordinated interplay on more or less equal terms. It is thus a question of building up, from the starting point of their different approaches, a common view that can constitute a basis for collaboration.

To achieve smooth cooperation between health and social service personnel, one of the difficulties to overcome is that each side tends to consider the other as necessary, but only subsidiary, to its own sphere of interest. In one of the Swedish centres the joint social–medical teams lacked any structured procedural framework, at least initially. Meetings were not prepared by a formal agenda, nor were official minutes kept of the meetings; each member of the team could raise any matter which he or she believed warranted a joint approach (*15*). As distinct from the hierarchical, well-structured team in the hospital, primary care teams should be flexible, often carrying out their functions in different places and in different groupings. Interactions among team members may be shifting. All this requires "a wide knowledge of each other's skills", greater awareness of social factors, and "greater inter-disciplinary and interprofessional understanding than has commonly developed in the course of health professional education" (*16*).

The primary care team in its narrowest sense is occasionally extended

by calling in other professional workers or by having the patient himself, and possibly members of his family, take part in some of the team's deliberations. The relationship between the primary team and specialists in particular can fruitfully be made more flexible if, instead of formal referral back and forth, the specialist can work within the team in appropriate cases, thus giving it the benefit of immediate consultation and, at the same time, becoming acquainted with the background of the cases. The involvement of a specialist as well as the generalist who is a permanent member of the team, again raises the matter of interprofessional relations. The visiting hospital specialist may also occasionally be joined by hospital-based nurses or by specialist social workers (*17*).

In the case of psychiatry, Brook (*18*) has described this kind of relationship between team and specialist in his own field and the points he raises will apply to a team's relationships with other specialists, especially in health care systems in which primary, secondary, and tertiary care traditionally operate at their own levels, relying on a well-structured system of formal referral. Deviations from this system will depend on the attitudes of the individual participants on either side, i.e. that of the specialist and those of the members of the primary care team. One can well imagine, however, that the experience reported by Brook will be paralleled in similar situations in a variety of health care systems. He relates the types of consultation developed between the team and himself as follows:

> Co-operation depends on regular meetings between the consultants and members of the practice team. Various types of contact are possible. I have found it helpful to carry out two types of consultation. I am available for a structured session with any member of the team who wishes to discuss particular patients, and I also attend a meeting of the whole practice team at which much less formal exchanges occur. There is a striking difference between the two types of meetings; they complement one another and it seems helpful to include them both. The more formal encounter involves commitment, in that the doctor or other member of the team implicitly acknowledges that he wants help for the patient or for himself in executing his professional responsibility; the less formal permits discussion, often tentative, of a wide range of topics with the whole team. These encompass both clinical topics, such as the difficulties in assisting a family where several caregivers are involved or the management of the hopeless case, and general ones such as aspects of personality growth problems arising at various stages of development.

The reactions to this approach are bound to vary among individual team members, affecting relationships between the specialist and particular members of the team. Such was the case in the situation described above:

> Not surprisingly the consultant's professional relationships with the members of the practice usually vary widely. He may establish a very close bond of mutual trust with certain members of the team and a distant but nonetheless satisfactory link with others. Yet with some he may have little or no contact at all.

The development of an effective and mutually satisfactory working relationship and the time taken to achieve it will depend on how conventional the structure of the system is and on the preconceived attitudes that may have to be overcome. In the case described, it took several months for an acceptable working relationship to develop and for new patterns of work to evolve.

A somewhat different relationship between consultant—also a psychiatrist—and primary care team was described by Cooper et al. (*19*). In this case, the team held fortnightly staff meetings to discuss new referrals and the progress of old patients, with special emphasis on the management of chronic neurotic illness. A research psychiatrist attended these meetings.

Another British study (*20*) lists questions that ought to be examined if the most effective coordination between the specialist and the primary care team is to be achieved. It notes that a number of health centres in the United Kingdom are already used by specialists for their outpatient clinics. This in itself, however, does not necessarily coordinate the two levels of care. It may be convenient for the patient, but inconvenient for the specialist. But the objectives in moving work conventionally performed at the hospital to the health centre certainly include the opportunity for meetings to discuss patients or policy regarding the management of certain types of case.

Similar arrangements have been reported for maintaining liaison between the primary care team and the paediatric specialist (*21*). In this case, direct contact was first established between the health visitors attached to the respective practices. Then monthly joint clinics were started, as well as special clinics for diabetic children, attended by their parents. And for slow or mentally backward children there are "developmental advisory clinics" staffed by a team representing all disciplines dealing with the medical, educational, and social needs of the patients.

Selected disciplines and their team roles

The basic, inner, or nuclear team consists of physician and nurse or nursing staff. This arrangement is not necessarily contingent on the existence of a health centre. Less structured groups of general practitioners lend themselves to team organization, and community nursing staff may even be attached to general practitioners in solo practice. The centre setting, however, facilitates the organization and operation of teams. Some health authorities in the United Kingdom will not build health centres unless participating doctors agree to attachment schemes for nurses (*22*). The nurse : physician ratio is variable, and the question has been raised whether nursing staff should be attached to the centre or to individual physicians practising in the centre (*23*). While the first type of arrangement may make for a more flexible administrative structure, the second type would be more likely to ensure that a patient is always visited by the same nurse, thus making for

greater continuity and improved patient–nurse relations.

As long as health centres and primary care teams operate and are administered as parts of the health service system, the physician will occupy a central role since it is his responsibility to determine clinical management. To what extent his central position also implies hierarchical superiority over other team members will be further discussed below. Some individual local centres, stations, or units may be headed by non-physicians, but these are usually linked to a central facility staffed by physicians. For the physician, more perhaps than for other members of the team, the team concept has two dimensions, i.e. collaboration with other physicians and collaboration with other health and community workers or, in the phrase used in the German Democratic Republic, "the family doctor and his collective".

As for interprofessional relationships among physicians, Freidson (*24*) has examined the various forms of association in the context of the loosely structured health care system in the USA, which has strong similarities with those European systems that do not have a state administered national health service. In such systems it is left very much to physicians to develop their own forms of collaboration within the framework of the laws in force and subject to regulation by their professional organizations. Freidson finds that true solo practice is a rarity and that some degree of "colleague network" is likely to be found even in the absence of formal cooperative practice. The "association" according to this author represents a simple variety of formal cooperation, while the small partnership and then the group practice are tighter and increasingly complex forms. The tightest and most formal variety of practice, generally existing in groups of more than five physicians, is organized on bureaucratic lines with hierarchical organization and extensive division of labour and functions within a framework of systematic rules, procedures, and controls. One aspect of interphysician relationships and teamwork is the variety of arrangements already described under which general practitioners and their primary care teams collaborate with specialists. A counterpart to these "custom-made" forms of interphysician relationship is to be found in the formally structured types of collaboration in the completely socialized health care systems, exemplified by the Bulgarian "brigade teams", which aim at increasing the effectiveness of medical labour and at rendering the medical care of patients under home conditions more efficient.

Reporting on the future of medical practice in Europe, a committee set up by the Council of Europe (*25*) recommended that hospital doctors should relate more closely to general practitioners by frequent meetings, and that hospital doctors and general practitioners should improve the flow of information on patients they have in common.

The physician's role *vis-à-vis* the non-physician members of the primary care team hinges largely on the extent to which his clinical responsibility does not impinge on the responsibilities of other team members in their own spheres, and how far his leadership fits in with the

concept of the non-hierarchical team. The Finnish policy of paying the health centre doctor a salary rather than on a fee-for-service basis has removed a discriminatory element that still exists in many other European countries.

The role of the social worker as a member of the primary care team is influenced not only by the factors determining interdisciplinary relationships, but also by the fact that the extension into the medical care system of the social services, which in most European countries form a separate administrative entity, introduces the stresses and strains of jurisdictional division into the team. This has been discussed more fully in a previous WHO study covering contrasting situations in four European countries (*26*). In many countries this situation has led to the social service being seen as an adjunct to the medical service, while in the context of some programmes aimed specifically at poverty groups, medical care is considered as supplementary to the social services. With the boundary-lines between medical and social needs becoming increasingly blurred and the corresponding services more and more interrelated—as in the care of the elderly, the physically or mentally handicapped, drug-dependent persons, etc.—the traditional dichotomy between these two major personal service sectors is becoming obsolete, and various ways of integrating them are being explored. Obstacles to full integration, apart from the interprofessional and interdisciplinary adjustments called for on the part of the individual workers involved, arise from the existence not only of separate administrations but also frequently of administrations at different levels, social services sometimes being based at the most local level while even the primary health services may be organized at a more central administrative level. Also, for the social services medical care constitutes but one of the many functions involved in helping families and individuals at the local level, while the health service system with its primary, secondary, and tertiary care organization must maintain ready channels of communication and referral between the different levels of care, a task that demands at least basic central planning, goal-setting, and financing.

The nurse on the primary care team should play a clinical role commensurate with her training. In addition, however, her contribution as a member of a multidisciplinary team has been described as being of "particular importance in helping humanize and personalize care, in interpreting patient needs to the family, and patient and family needs to other members of the health care team" (*27*). The health centre setting has been seen as facilitating the rational allocation of resources for such non-nursing functions as reception and administration, thus tending to free the nurses for nursing duties (*28*). In common with that of other members of the primary care team, the nurse's presence there may be the result of a variety of organizational arrangements: she may be employed by the agency operating a health centre or by a doctor or group of doctors, or she may be "attached" to a primary care team while formally employed by some other agency.

A Yugoslav study (*5*) found self-esteem in the nurse to be closely

correlated with acceptance by the physician and, in turn, self-esteem in the physician to be positively correlated with the nurse's self-esteem; physicians and nurses cooperate better the longer they have been working together. Better acquaintance by physicians with the nurse's potential contribution, at least through some familiarity with nursing school curricula, would stimulate better cooperation.

As indicated in Chapter 2, a great variety of other categories of personnel may participate in what is sometimes described as the extended primary care team. Depending on the size and scope of a health centre or free-standing team, such personnel may have only a loose connexion with the team, as has been shown to be the case with certain specialists. This group includes the various therapists and technicians, for example members of the remedial professions such as physiotherapists, whose services are assuming increasing importance as health policy in most countries places greater emphasis on community care for the elderly and chronically disabled, as well as for patients recovering from acute conditions. In many countries physiotherapists have achieved a considerable degree of independence in relation to other health professionals, including physicians, and in some countries they may treat patients even without physician referral. Nevertheless, a study by Partridge & Warren (*29*) stresses the need for physiotherapists to collaborate with other professions, if not as members of a hierarchically organized team, possibly in case conferences or on joint committees. But whatever form their collaboration may take, the prerequisites are "confidence on the part of each participant about his own role and contribution to the care of the patient and an understanding, acceptance and appreciation by each collaborating person of the role and contribution of all the others concerned". The physiotherapist, therefore, must inform the team about the scope of modern physiotherapy and pass on some of his skills and expertise to others, such as nurses. Nutritionists, dieticians and other health professionals are in a similar position.

As indicated in Chapter 2, members of certain non-medical professions are potential contributors to patients' wellbeing. The best known of these is the social worker, but lawyers, marriage counsellors and ministers of religion have also been considered as essential contributors to the primary care team in some situations, although their actual participation may not be on a full-time continuing basis but of a periodic, occasional, or "as required" nature.

The non-hierarchical team

It should be said at the outset that members of many functioning primary care teams will be puzzled by being asked whether their teams are hierarchical or non-hierarchical. They will regard this as an academic issue that in practice does not arise. Admittedly, however, theirs is obviously a situation in which teamwork has been functioning smoothly because of the explicit—but more often implicit—adoption of

the principles established in the literature regarding the prerequisites for effective teamwork.

At the centre of the argument is the role of the physician on the team; in view of his clinical responsibility for the management of the patient, must he not be the hierarchical superior of the other team members? Can he, in charting a course of treatment, submit to a majority decision by other members of the team? These are questions that apply, *mutatis mutandis*, also to the other team members in their particular spheres of competence: the social worker, the community nurse, the physiotherapist, the dietician, and the other permanent or occasional members of the team.

What sets the physician apart in many European countries is not only his clinical prerogative but his method of remuneration, i.e. by payment-for-service whereas other team members are salaried. Hence the Finnish decision to pay health centre doctors a salary. In a similar vein, a proposed policy statement by the Canadian Public Health Association (*30*) specifies "that remuneration of the health team members must be mutually non-exploitive in nature; it must be based on their respective roles, functions and responsibilities; it must be comparable to equivalent areas of professional practice". The elimination of such discriminatory administrative practices will go some way towards bringing about the necessary team spirit. Beyond that, however, it is not a question of depriving the physician of the clinical role for which his training has prepared him, but of recognizing that he is not automatically the last authority on all matters of concern to the team. "Physicians are by no means the leaders of every team to which they belong" (*25*) and "the traditional concept of team leadership being *ipso facto* the prerogative of the physician should be abandoned in favour of a flexible leadership which can be vested in whichever member of the health team can fill the role most appropriately in any given situation" (*30*).

The dilemma as it affects the pluralistic systems in Europe—characterized by largely public financing of largely private resources, the form of organization being left to the devices of individual professionals—is aptly described by the Belgian Ministry of Public Health and Family Affairs. Health centres in Belgium generally aim at a non-hierarchical and non-competitive relationship among team members with the distribution of tasks based on each member's competence and the tasks coordinated, not just juxtaposed. Despite the intention to establish such a relationship, however, experience has shown its complete achievement to be difficult, if not impossible. The reason is the specific role of the physician as the hub of all medical activity. Nevertheless, non-physician members of the team do play a leading part in certain diagnostic procedures and in the decisions of therapists in their particular fields.

A study of politics and conflicts in an American neighbourhood health centre (*31*) approaches the problem cautiously and, while opting for democratic teamwork, qualifies this by demanding that the team be "as democratic as possible". While the physician's expertise is

recognized in some areas, the knowledge and skills possessed by other team members are emphasized by the advocates of teamwork "in an attempt to maintain a balance or even equality among all health workers".

In the context of a state-operated, monopolistic health service, Czechoslovakia offers a realistic approach to the question of reconciling the principle of the physician's responsibility within the framework of a linear organization with a non-hierarchical relationship within the team. The solution offered is recognition of the parallel existence of two organizational principles: on the one hand, there is the relationship of direct organizational subordination but, on the other, account must be taken of intrateam relations resulting from "methodological guidance". Both figure largely in primary health care in Czechoslovakia but, for the effective performance of the physician's duties and those of other health workers, the existence of an informal, i.e. non-hierarchical, relationship between them is of great importance. Referrals from general practitioners to specialists at the polyclinic or hospital involve partly a semi-hierarchical relationship and partly a non-hierarchical, informal one. The high degree of integration in Czechoslovakia's socialist health service is seen as favouring the development of durable informal relationships which work smoothly and are elastic. Both the formal (hierarchical) and informal (non-hierarchical) relationships in the service are the subject of research. New stress on community-wide preventive programmes favours the expansion of traditional teamwork in primary care by the greater involvement of more first-line workers and closer relationships with other community services, including voluntary organizations.

As distinct from primary care, the care of patients in hospital has always been shared by several categories of personnel, almost invariably on a hierarchical basis with clinical activities determined by the physician and the administrative aspects subject to the decisions of an administrator, a delicate balance being sought between the medical and administrative direction of the institution's work. But even in the hospital a *de facto*, if not *de jure*, erosion of the strict hierarchical structure may be detected as professionalism and professional awareness increase among non-physician personnel. Additional factors are involved, however, at the level of the primary care team. What Nicolausson (*16*) observed in Sweden holds good for other health care systems too. He contrasts the easily recognizable team in the hospital, especially in the operating room, with the primary care team. The former is organized "in a hierarchical, well-disciplined fashion with clear delineation of responsibilities, and the team members work together at a single point in time with a single common objective" and, one may add, at the same place. The activities of the primary care team, on the other hand, "are far less focused and the handling of a patient's problems may extend over months or years. It is often carried out in different places by different team members. The members of the primary health care team must be prepared for flexible and shifting interactions among themselves

and others, must have a wide knowledge of each other's skills and must be capable of independent activity". It is the degree of independence in the team members' activities, combined with their ability to rationalize them for the benefit of their colleagues on the team, that determines the degree of non-hierarchical teamwork.

Nicolausson's reference to interactions among team members "and others" points to another factor determining the team's mode of operation. Once the team adds non-health workers, for instance a social worker, to its members, it expands beyond the health field in the narrower sense, i.e. beyond the sphere of medical knowledge and skills. In this case the question of first access also arises (*22*):

> If social workers are to be included in the team, the doctor as sole or main agent of first contact would be unacceptable. Instead cross-referrals and case conferences would be necessary, the patient choosing whom he first wished to see. This would involve "multiple access" for the patient, for which guidance would be needed. Health centres provide a physical basis for multiple access, as the patient need only go to one place, and can be conveniently referred to other personnel in the same building.

Leadership then is not automatic, and it has been said that the worst kind of teamwork is the kind that suggests a hierarchical arrangement "with one professional group as the hereditary captain or leader giving instructions to the other members of the team" (*29*). This statement occurs in a consideration of the physiotherapist's role on the team. Among the medical and allied personnel on the team, some generally acceptable semblance of hierarchical arrangement—of informal, if not formal, leadership—may evolve as a result of specific tasks being related to specific skills in a hierarchical order corresponding to the levels at which the tasks are carried out (*32*). It is increasingly the actual function of each team member that is recognized as determining the style of team operation, rather than predetermined and status-bound linear relationships. Relationships thus become associative rather than scalar (*33*) and one moves away from the traditional bureaucracy towards a flexible and directly task-oriented "adhocracy" (*6*).

Another conception of the team is gaining ground that widens its scope beyond that of the providers of primary care, thus further eroding the automatic dominance of any one professional group. A sociological view, in which teamwork is seen as the central concept of the health centre, extends the idea of the team beyond the division of labour among the providers of care to include the patient and the community of which it is part (*34*). Crichton contrasts the "paramilitary system" developed in hospital operating theatres for largely "inert patients" with the "milieu therapy approach", first developed in mental hospitals and later in community psychiatry. In this, the focus shifts from the physician as team leader to problem-solving processes for the patient: "naturally, the physician is better equipped to diagnose organic problems, but other members of the team may have more useful contributions to make to psycho-social or social difficulties, and this approach focuses upon helping the patient to take greater responsibility

for his own health . . . and the community to take greater responsibility for its members". The emphasis on the consumer accepting greater responsibility for his own health has modified the traditional idea of the patient surrendering his own initiative and potential contributions on entering the health care system and resigning himself to a passive role *vis-à-vis* the experts (*35*).

In brief, then, there is widespread agreement on the concept of a team of equals, ultimately perhaps managing its patients by consensus, but there is also a recurring emphasis on the physician's leadership in deciding on clinical matters and on the shift of leadership to other team members as the case requires. Surprisingly, many primary care teams do work smoothly without worrying or even being aware whether they are hierarchical or non-hierarchical. How could an outside observer identify a particular team as being of either description? For this, it is necessary to go back to the criteria already mentioned of attitudes and recognition of other team members' knowledge, skills, and potential contribution to a particular case. The field of social psychiatry provides the following examples of both types of team relation (*36*). Here the concepts of hierarchical and non-hierarchical are transposed into "parent-type" and "adult-type" respectively. Miller takes the common example of the working relationship between psychiatrist and social worker:

> The psychiatrist who says "I will get my social worker to visit" is taking a patronising and Parent-type approach since his attitude is like that of the parent who is saying "I will get my little girl to call round".

The incriminating words here are obviously "I will get" and "my". The alternative sounds simple enough:

> But the same sort of statement may be made in the form "I will discuss with the social worker the possibility of a visit" and this takes the form of an Adult-type approach, i.e. like adults talking to adults. There is no difference between these two approaches in the organizational set-up of the team, only a different attitude reflected in the wording of a statement or perhaps merely in its tone. From the social worker's end, the corresponding statements may be respectively "I will ask Dr X what he wants me to do" or alternatively "I will discuss with Dr X what is to be done".

Indications of the attitudes of some team members can sometimes be found in the correspondence columns, for instance in the following exchange in a British journal. The first excerpt is from a letter by a health visitor, reacting to an earlier statement by a physician: "one hesitates to suggest a strong smell of male chauvinism combined with an over-inflated ego. . . . We are supposed to be equal members of the Primary Health Care Team and [for] the doctors to assume the position of 'leader' or 'co-ordinator' is in no way automatic or God-given" (*37*). This prompted the following question from a physician: "Can you really expect professional parity with the general practitioner who is truly an independent professional and responsible only to his/her patient?" (*38*). These are sentiments which often remain unsaid or are said in more diplomatic language, and contributors to the correspondence columns

are usually those who feel most strongly about an issue or have an axe to grind.

If it was said earlier that members of existing primary care teams would often consider the question posed here as academic, this applies to teams that are functioning either because they have come to be accepted as an integral part of the system or, on the other hand, as experiments or demonstration projects with an element of self-selection of congenial personnel. The above examples, however, illustrate that there still is a widespread lack of the necessary team spirit, i.e. attitudes and opinions conducive to working with other professionals. Some 15 years ago Elling (*39*) observed that in the United States there was only a very gradual change from a leader–follower relationship to a colleague relationship on the team, as reflected in the terms used to describe the non-physicians: "after imperialistically referring to 'sub-professionals' for years and recently modifying this to 'ancillary professionals', the vogue among physicians now is to speak of 'allied professionals'".

How can the situation be remedied so that the professionals on the primary care team are adequately prepared to work effectively with their colleagues?

Preparation for teamwork

The art of getting along and working with others—be it a natural trait or acquired through training or experience—is a requirement for effective functioning in any organization, including the primary care team. But there are certain factors peculiar to this team, and it is on the awareness and appreciation of these factors that preparation for effective teamwork must be based.

The objective of the team, common to all its members, is the promotion, preservation, or restoration of people's wellbeing. Increasing understanding of the various components of this wellbeing and how to deal with them has led to a progressive division of labour and thus to the evolution of the multidisciplinary team. Traditional training in each of the disciplines involved has concentrated on the requirements and tasks of that particular discipline, more often than not with little or no reference to the contribution by others to the wellbeing of the people to be cared for. Moreover, professionalization, for better or worse, has provided practitioners of the various disciplines with a greater sense of confidence and independence, incompatible with such hierarchical terms as "auxiliaries", "para-professionals", and the like. The concept of health itself has broadened into a recognition of the interrelationships among physical, mental and social wellbeing. It would be wrong to assume, however, that all health problems accordingly require a multidisciplinary approach: injuries and acute illnesses, which still account for the bulk of health problems, fall strictly and exclusively within the competence of the doctor, the nurse or some other health professional, while many social problems are unrelated to either physical or mental health. Yet the increasing problems of the elderly, the

chronically ill and the handicapped, and the emphasis on health maintenance and prevention on the one hand and the total rehabilitation process on the other, call for many different types of expertise and skill. The hospital provides for the total needs of its inpatients, including accommodation and feeding; as hospital care is replaced by care in the community this, too, must have regard to the patient's total needs, not just the medical or social ones.

People are trained to serve all these needs and to do so efficaciously, but it remains for the team to coordinate its separate efforts into a holistic approach. It has been said time and again that this can be achieved only if each member of the team is aware of his own role as well as of those of his colleagues and if he respects the ability of the other members to perform their roles adequately.

This awareness and respect are based on mutual knowledge which, like any other kind of knowledge, must be acquired. To facilitate this was one of the aims of the United Nations in establishing the European Centre for Social Welfare Training and Research (*40*). Its report on the subject bases its approach to the problem on a broad concept of social welfare, including social services in the narrower sense as well as health and other personal services. It refers to the need for "broad interdisciplinary understanding and co-operation among those involved" with certain client groups including, among others, the elderly, the young, the handicapped, and those dependent on drugs. Consideration should be given, the report continues, to "the application of a common core to training for a variety of professions with widely different requirements and conditions of work, more or less directly concerned with problems of social welfare". This must be based on the appropriate "training of trainers at an advanced level", applied at the basic training stage or in refresher courses. The report suggests the establishment of "training courses on field-work supervision of social welfare and related personnel" to bring together the people concerned with the coordination of professional efforts. Aspects of the training of public health and social welfare personnel "who render similar and related services to the same group of people" were specifically singled out for study. The subsequently established European Centre has held two meetings devoted to collaboration between the health and social services.

In some educational institutions such as, for instance, the polytechnics in England, several of the primary care team disciplines are taught, including community nursing, health visiting, and social work; some training for general practitioners is also given. For a working group concerned with the improvement of team relationships, a polytechnic teacher outlined the problem and possible solutions in a statement, most of which has general validity and from which relevant observations are quoted below (E. Baker, unpublished data, 1976).

—When to train?

It would probably be true to say of most primary health care teams that they have learned to work together as they went along rather than having been

given deliberate training at any point. However, there are three points at which training in team work might be possible:

(*a*) in basic training, i.e. before registration as professional workers. Among nurses this might be part of registered nurse training; among doctors, part of the training of those opting for general practice; and among social workers, part of their academic course.

(*b*) in post-basic formal professional training.

(*c*) at the point where the primary health care team is being formed.

Since (*a*), (*b*) and (*c*) are virtually in chronological order, the form of training could not be the same for each but would have to be adapted to the increasing maturity and experience of those taking part.

—What is the purpose of training?

If the team is to work together more effectively, it is necessary for

(*a*) each member to know enough about the area of expertise of each of his colleagues to be able to recognise the point at which consultation or referral becomes appropriate.

(*b*) each member to be aware of the unexpressed conventions and limitations of each of his colleague's professions.

(*c*) all members to experience and come to terms with the dynamics of group work.

—What are the premises on which the work of the primary health care team is based?

These are probably five:

(*a*) the needs of the patient/client are primary, i.e. they take precedence over the categorical professional interests of the professions.

(*b*) the skills of each member of the team may, possibly at various stages, be equally relevant to the patient's condition.

(*c*) the patient, and possibly also a member of his family, is a member of the team.

(*d*) all the professions may contribute to the diagnosis and consequent therapy, the significance of each contribution being determined by the team's perception of the condition.

(*e*) the leadership of the team will lie with that profession whose contribution is seen to be most relevant, i.e. it is not to be determined automatically by the relative status of each of the professions involved.

—What are the difficulties of team training?

These are of three kinds:

(*a*) of attitudes

i. of the professions
ii. of the patients/public

(*b*) of substance

(*c*) of logistics

(*a*) of attitudes

i. of the professions

— an unwillingness (though fortunately decreasing) to recognise the psycho-social causation of much illness.

— an unwillingness to accept the parity of the professions. This is partly the result of a training which makes both doctors and nurses accept the role of the doctor as leader. In contrast, there is a distinct, at times almost aggressive insistence by the social worker on his/her independence.

— a difference of orientation within the profession, particularly of medicine which has hitherto given pride of place to institutional medicine and, within that, the consultant.

— a difference of orientation between the professions which makes the social worker more community orientated and the doctor/nurse more hospital orientated (fortified to some extent by the difference in administrative accountability).

— difference in age, maturity and prevailing sex.

ii. of patients/public

Public attitudes have tended to reflect those of the professions, i.e.

— to give priority of esteem to institutional medicine and, within the institution, to the consultant.

— to accept that the duty of the patient is passively to obey the doctor's/nurse's orders. This has been transferred to the social worker whose sanction for refusal is not that of withholding health, but of withholding benefits.

(*b*) of substance

Medicine and nursing are clearly symbiotic professions; consequently, much technical knowledge is common to both. This is less true of the social worker's technical knowledge. Leaving aside the question of whether a more comprehensive view of illness should not lead to a revision of a wide area of training material, there are certain areas to which medicine and nursing are paying increasing attention (these are topics which form the staple of much social work training):

— developmental psychology, i.e. a patient is no longer solely a bio-physical phenomenon.

— sociology, i.e. the patient is intimately affected by the way in which society sees him and he sees society.

— social policy, i.e. the provision which society makes for the incidents of individual malfunction.

— social medicine (patients as bio-physical–psychological–social phenomena).

— community health or medicine (social environment).

A fourth topic, group dynamics, is given some attention in the training of social workers, but little in preparation for the other professions.

(As the concepts of bio-physical and psycho-social disease and of the primary health care team become more fully developed, is it conceivable that the training of all three professions might include an element of health

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education—at present included in that of health visitors—encouraged perhaps by the establishment of more patient-committees and that a place might even be found for some element of community work?)

(*c*) of logistics, i.e. time and place

Five simple but very difficult problems are:

—the point of entry. On the whole nurses begin their training at an earlier age than doctors and doctors than social workers.

—qualifications for entry. Medical students are selected from high achievers at school; the same is not, on the whole, true of nurses. Social workers may or may not be high achievers.

—the length of course. Training for medicine takes six years, that for social workers and nurses only about one third of that time.

—the geographical place of training. Nurses throughout their basic years, doctors in their clinical period, are trained in hospitals, i.e. in a mono-technic environment, social workers in a poly-technic environment.

—the lack of any articulate post-basic training for social workers as compared with nurses and, to a somewhat less extent, with doctors.

—What are the possibilities of team training?

(*a*) in basic training. There is clearly scope for education in some or all of the four topics mentioned above in the medical student's clinical years, especially where he has opted for general practice. It is an open question however whether he/she should be matched with the nurse and social worker in their pre-registration training. Disparity of experience and training might be too great.

(*b*) in post-basic training. Here the experience of a doctor, nurse and social worker might be more nearly equal and the possibility of devising both seminars and situations of practical training which would bring all three together might be explored.

(*c*) would call for a series of planned lectures and seminars for a selected group of professionals who knew they were going to work together.

The benefit of training in team work at points (*a*) and (*b*) is that it would presumably be early enough to influence the attitudes of large numbers simultaneously. At stage (*c*) the numbers dealt with would be smaller (and, therefore, more expensive) but a high level of motivation could be assumed.

Some of the measures Baker mentions are already in operation in various countries, more often on an experimental basis or as demonstration projects rather than as universally accepted routine procedures for the training of all members of the multidisciplinary team. It has been said of the curriculum and teaching methods in the medical schools in Sweden that there is hardly any joint teaching of medical students and nurses or assistants, but in the time they spend in wards and outpatient departments students do receive some team training with other personnel groups (*41*). This, of course, holds equally good for many medical schools elsewhere in Europe and applies not only to the time spent by the student in hospital outpatient departments but also to

the student's attachment to urban and rural practices and health centres.

More specific approaches, deliberately focusing on the preparation of teamwork, are discernible in recent revisions of medical curricula, especially those for training in general practice. These recognize that the general practitioner "will practise in co-operation with other colleagues, medical and non-medical" and that, therefore, at the conclusion of a training programme the doctor should be able to demonstrate, among other things, "the capacity to co-operate with medical and non-medical professionals" (*42*). While this report refers to developments in western Europe, established practice in eastern Europe may be exemplified by Romania, where practical work in the first- and second-year curricula includes visits with doctors and their assistants to patients' homes and various institutions, providing the student with "much practical knowledge about the auxiliary medical personnel's daily activity" (*43*).

Specific methods for achieving these general objectives are finding their way into the curricula. At Queen's University, Belfast, for example, the objective of an effective communications network within the team, between the team and the hospital, and between the team and other community services is to be met by fifth-year general practice teacher attachment so that by the end of that year the student should be able to demonstrate, apart from clinical proficiency, "some knowledge of the communication system in this country within a practice, a primary care team" and between the team and other agencies. Case presentations will demonstrate the roles of different professionals in the primary care team, with a half-day session set aside for illustrating and discussing aspects of teamwork. Following fifth- and sixth-year attachments, each student is to present a brief history of case discussions held with members of the primary care team (*44*).

In Glasgow, recent changes in the teaching of general practice provide an opportunity for the student to make visits together with health visitors and social workers and to gain insight into the work of the clinical psychologist. This was found to fill a gap "because didactic learning of job descriptions is no substitute for personal interaction in understanding other professions involved with primary care" (*45*).

In a London project (*46*) it was found that by the end of a course in family planning training, multidisciplinary activity had provided greater understanding of the roles and responsibilities of each discipline involved and a greater appreciation of each discipline's particular problems. The particular courses described consisted of six 3-hour sessions, four of which were interdisciplinary with 8–10 participants, including doctors, nurses, social workers and teachers.

Measurable results of basic training in teamwork are still rare, partly because of the recent origin of these programmes. One study from the United States, described as "preliminary" (*47*), aimed at evaluating a 12-week course in which seven disciplines were represented: medicine, nursing, education, nutrition, premedicine, communication and counselling. All students were in their early stages of training. Learning was

found to be significant in the area of team skills and processes and in the knowledge and abilities in client communications. This was not the case, however, with regard to physical assessment, a field of secondary importance in the design of the course.

There are numerous programmes in many countries providing interdisciplinary training sessions for those already working in the field. Among the problems encountered is that such programmes often have to overcome already established attitudes and prejudices. For both undergraduates and graduates there is the question of the most appropriate stage at which the various disciplines can be brought together. It is probably easiest to design a common core curriculum early in their respective studies, but it has been demonstrated that the attitudes and expectations of medical students change over the years. Therefore, for the medical curriculum the later years may be chosen.

A study at the Miami School of Medicine (*48*) set out to examine differences among medical, nursing and social-work students, and to compare changes in their respective "dogmatism" during their first academic year. Medical students emerged as the most and social-work students the least "dogmatic". During the year both medical and social-work students became less "dogmatic", with no significant change among the nursing students. The authors conclude "that a good time for naming positive attitudinal change in professional education is during the students' first or second year. At this period in their training their belief systems appear still to be open, indicating relative flexibility and readiness for assimilation of new information and approaches."

Another programme of interdisciplinary health education in the United States brought together students for a course lasting several weeks at a later stage in their training. Evaluation of the fourth-year students in medicine, nursing, dentistry and pharmacy, and of first-year graduate social-work students who participated in the course, showed a change in the students' "knowledge, acceptance, and use of skills practised by the other disciplines" (*49*).

Joint education and training for teamwork has been proposed by a number of WHO working groups. One such group, which met in Reykjavik in 1975 and was concerned with defining parameters of efficiency in primary care (*50*) recommended joint training at both the basic level and in further education. Simultaneously, a group examining the role of nursing in primary care viewed joint education as a "prerequisite for the effective development of primary care on a team basis" (*51*). A group meeting in Dublin in 1976 to deal with the continuing education of health personnel (*52*) observed that in existing training programmes physicians may contribute to the education of nurses and occasionally to that of social workers, "but the reverse is virtually unknown". The resulting recommendation was that, among other activities, WHO should encourage and support the development of demonstration projects in interprofessional education.

Going beyond the incorporation of joint education into existing curricula Fry, a general practitioner, has suggested establishing "a

faculty of primary health care that should include and involve all those working in this special field of care" (*53*). The proposed structure of such a faculty is not further explained, but any of the programmes variously suggested could be accommodated fairly readily within the framework of a health sciences centre or any other institution (such as a polytechnic in Britain) where most of the relevant professional training is provided. In its comments on health centres and primary care the Icelandic Ministry of Health and Social Security states the belief that difficulties and friction among team members result from lack of communication among the schools for health sciences, and that the task for the future is "to integrate the teaching and training of health professionals to the extent that they may better understand the role and appreciate the skills of their fellow workers".

In this report only a few selected examples of existing programmes can be cited, but the innovative character of training programmes and their importance for the future effective functioning of the primary care service would make it worthwhile to undertake a systematic survey of existing and developing programmes in the various educational institutions training future members of the primary care team.

Providing a structure for interdisciplinary training and work

It is clear that the basis for teamwork must be laid in the minds of the members of the team, but organizational measures can strengthen—or weaken—the team's effectiveness. As Partridge & Warren (*29*) point out formal arrangements, such as a decreed hierarchical order or provisions for regular case conferences or joint committees, have their place even if by themselves they will not produce effective teamwork.

In small centres consisting of one doctor and his associates—e.g. a nurse and a social worker—it is usually the doctor who assumes the managerial function, assisted perhaps by a secretary/receptionist who looks after the clerical tasks: "Indeed, at the present time many doctors are managed very efficiently by their secretaries, even if some of them do not have the grace to admit it" (*54*). Larger groups of doctors functioning with their teams in one centre require a trained administrator akin to that in a hospital, but who appreciates the difference.

That the method of remuneration may affect the working of the team has been noted in connexion with the decision in Finland to pay doctors a salary and thereby put them in this respect on an equal footing with the other team members. As noted above, the question of remuneration was also considered by the Canadian Public Health Association (*30*) in its proposals for the strengthening of teamwork: "remuneration of the health team members must be mutually non-exploitive in nature; it must be based on their respective roles, functions and responsibilities; it must be comparable to equivalent areas of professional practice; it must be supported by incentives to achieve the stated goals of the health delivery

system". While this recognizes the importance of methods of remuneration, it falls short of making specific recommendations.

Provision for regular meetings and case conferences can provide a framework for stimulating cooperation within the team. But even where such a provision exists, it may be used in a hierarchical fashion unless all members of the team participate equally in making the necessary arrangements. A study of nurse attachments in Canada (*55*) revealed that out of 93 practices 69 had regular team meetings, but in 13 of these the nurse did not attend; no formal meetings were held in the other 24 practices. The limited involvement of the nurse in initiating team action was also evident, in that in 21 of the practices studied referrals to the nurse were entirely at the initiative of the physician.

Provision for meetings and case conferences implies that the team members work closely together, ideally under a common roof. Sharing of equipment and rooms is considered by the British Department of Health and Social Security to facilitate harmonious working relationships among team members. Where the organization of their practice is left to the general practitioners themselves, as it is in the United Kingdom and the pluralistic systems in Europe where doctors are not employees of the state, the state can at best encourage and provide the physical facilities of a health centre for those willing to practise there. A similar idea is behind the proposal for a "thrust fund" for the development of community health services in Canada. From the point of view of the central authority, closer cooperation between the health and social services may result in "organizational advantages and work-routine simplifications" (*56*). In Denmark the Municipal Councils Association has issued guidelines for a one-stop system of health and social services. Because here (as for instance also in France and the Federal Republic of Germany) the legally established freedom of the medical profession and the principle of free choice of doctors and dentists present obstacles to the complete incorporation of these professions in the teams, several municipalities are experimenting with different models of systems for communication and cooperation.

An extension of the primary care team concept appears in the care of the chronically ill and in rehabilitation, owing to the various stages of care between primary and secondary or tertiary care. This requires an organization, in Poland referred to as a "unified health system", where the hospital and local dispensaries are combined under the administrative supervision of a director (*57*). A proposal by trade unions in the Federal Republic of Germany, for integrated medical systems in which all the technical services would be concentrated in centres used by hospitals as well as panel doctors, goes some way towards such a broader concept of the team and integration of various levels of care (*58*). Similarly, the Scottish Home and Health Department emphasizes the importance to the primary care team in a health centre of the ready availability of laboratory and radiological services.

The British practice of nurses being either "attached to" or "employed by" general practitioners clearly establishes, at least

administratively, an employer–employee relationship (*54*). This arrangement is not necessarily carried over into the team's work, but it does establish a basic framework prejudicial to the concept of equal status, as distinct from the situation where both doctor and nurse are employed by a third party such as a health centre or the agency operating such a centre. To achieve such equal status was also one of the considerations behind the Finnish policy of paying health centre doctors a salary.

Records and confidentiality

One structural factor that can make or break effective teamwork is the policy and practice regarding access by individual team members to patients' records and files. Mutual access to records is important in maintaining trust and confidence among the team members, but it may become a bone of contention because of concern over the confidentiality of each team member's records, particularly between the medical record and that of the social worker. Where common records do not exist or the exchange of records is not officially sanctioned, team members may surmount this difficulty by discussing relevant aspects in case conferences or in personal conversations without resorting to the actual records.

The dilemma between the need for shared information and the preservation of confidentiality was brought into focus in Britain when, in the course of a reorganization of the health and social services, medical social workers became employees of the local authority instead of the hospital. As a result, the social worker's accountability and responsibility for files shifted to the social service department. An editorial in the *Health and social service journal* (*59*) saw the solution in acceptance of the concept of "the caring team" with collective responsibility for the patient. Complaints are apparently relatively rare and "it is obvious that very few clients have anything like a clear idea of the exact limits of information flow even within the hospital". In regard to the social service file, the editorial suggests that the social worker in the course of the relationship with the client should "express as honestly as possible the scale of the caring team and the sort of information-sharing on which team work is based."

In the hospital setting the limits of the team are relatively narrow and clearly defined. In general practice, however, case conferences may draw on wider expertise, and one general practitioner was worried by the fact that the contents of medical reports may be communicated, for instance, to a local councillor (who is a politician), local housing officials, representatives of gas or electricity boards, or the police, any of whom may be called on to participate at some stage of the case. The solution then is that "either doctors must alter their ethics or the other people involved must stick by the same principles as the medical profession" (*60*).

The question of access to records is, of course, part of the now very topical argument about personal records kept not only by health

agencies but also by many other institutions in society. In regard to the primary care team the answer probably lies in the fact that not all records, or not necessarily all parts of a record, have to be seen by all team members and that in many situations verbal or written abstracts may suffice.

From the point of view of health, the family oriented approach to primary care is as yet poorly developed in the European countries, although it is quite common in the social services. Existence of a family record adds another dimension to the question of confidentiality regarding individual members of the family.

The team in perspective

Most of the discussion of teamwork and the bulk of the literature on the subject centre on the clinical team, i.e. those providing services to the patient and primarily those having direct contact with the patient. This concept includes members of the remedial professions such as physiotherapists, but technicians would at best be borderline cases. The receptionist and some administrative personnel may have contact with the patient, but not as part of the caring process. A larger centre may house several teams so that the relationships between administrative personnel and a particular caring team will be diffused, and this applies to a still greater extent to maintenance or housekeeping personnel, drivers and others who serve in the centre.

The boundaries of the team are therefore somewhat vague. The team members may sometimes be known as the "professionals", not necessarily because of higher standing in the hierarchy but because of their specific training to provide the services that are the aim of a primary care organization. The potentially important role of the receptionist or secretary in determining the quality of the relationship between a centre or team and its clientele was stressed earlier in this report. One study (*22*) describes the tensions, or problems of what it calls etiquette, in the relationship between the "professionals" on the team and the secretariat. It cites the example of a senior secretary who is supervising the appointment system:

> She can supervise the receptionists and tell them what system of booking to follow, but the doctor may disrupt all the arrangements, by for instance, fitting in extra patients on demand, which the receptionists had not planned for. The senior secretary has no authority over the doctor, and is of lower status, and so has to ask, and not to tell, him to alter his system.

Especially in a larger health centre, the relationship between the health professionals and the administrative staff is not unlike that in a hospital. Generally speaking, however, it would seem that particularly in larger hospitals, which require managerial direction of a more businesslike nature, the administrator's position *vis-à-vis* his medical counterparts will be stronger than it will be in a primary care facility; consequently, the study just referred to found that:

> In a whole range of matters, therefore, the administrative staff have to rely on co-operation and negotiation with the professionals for the running of the centre, using persuasion if possible. In these circumstances, the committee structure becomes more important.

One could compare such an uneasy equilibrium with the team concept in the management of the reorganized British National Health Service. That service has at each administrative level a management team of officers—including a medical officer, nursing officer, treasurer, and administrator—all of whom have equal status so that these teams can be described as consensus-forming groups of equals. In this respect they resemble the Security Council of the United Nations with its provision for powers of veto. At the managerial level it will be fairly easy for the team to act on such a strictly non-hierarchical basis because all members share equally the responsibility for the direction of the service. The physician, however, still has a primary responsibility for the clinical management of a case, with other team members assuming similar responsibilities at various stages of a case.

In their hospital system, the British refer to the "cogwheel" mechanism which coordinates the managerial functions of the various categories of hospital staff, including nurses and administrators. Here there is also a link with the community services, specifically those of the general practitioner who, therefore, should also become part of the cogwheel mechanism "to improve communication and in some matters lead to better decisions" (*61*).

Acceptance of the team concept

To many actually working on primary care teams in the variety of health care systems that exist in Europe, effective intra-team relations seem to come naturally and there is ready acceptance of leadership by one team member or another as a particular situation warrants it. Under these circumstances it does not matter whether the team is hierarchical or not.

Where the choice of working on a team or in a health centre is up to the individual, there is of course a natural selection based on personality, ideology, or special training. In other situations, where teams and centres are a universal feature of the system, all professionals concerned will automatically accept it and be prepared for it. In some cases the other team members may tacitly accept a certain amount of leadership by the physician, leaving it up to the physician whether he exercises his role autocratically or leaves certain aspects of the work to others.

Recognition of the team approach as being beneficial to the patient is one factor in persuading the different professions to work together. A rather limited survey in only one health centre in New Zealand showed that of 25 "allied health personnel" interviewed, 23 agreed or agreed strongly that patient care is more effective when working as a member of a team (*62*).

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In many situations there remains some difference in the degree of mutual acceptance between the health side of the team (i.e. doctor, nurse, midwife and other health professionals) and the social worker. The findings of a sociological study among some Canadian group practices (*63*) are not confined to that country when observing that "in general, physicians feel more at ease with referrals to physiotherapists, nurses and other obviously identifiable paramedical staff than to social workers". The latter, on their part, are "less prepared to acknowledge the authority of the physician and claim to have their own kind of expertise in diagnosing and treating cases." The same may be said of other non-medical potential team members such as psychologists, dietitians or nutritionists.

As distinct from the multidisciplinary primary care team—essentially doctor, nurse, social worker—the relationships among several physicians within a group depend on the nature of the group, i.e. the extent and content of the contacts among the physicians. It applies to the relationship among several general practitioners, but takes on another dimension when it comes to the interaction between generalist and specialist. Where the organization of a group practice results from the private initiative of individual physicians—as in many cases in central and western Europe and North America—another element is added to the need for personal and professional compatibility, i.e. agreement regarding the financial operation of the group including the method of remunerating the individual partners. One of the attractions for joining such a free-standing group or a health centre which is part of the system, is the fact that a new physician does not have the considerable financial outlay involved in setting up an independent practice. On the other hand, the joint financial operation may be a cause of friction among the partners.

Some aspects of consumer or patient reaction to the primary care team have been mentioned in connexion with records and their confidentiality. Others relate to the degree of acceptance of the health centre concept generally, and will be discussed later in the report.

Teamwork in management and clinical services

Management by team and patient care by team are two different dimensions of teamwork and one does not necessarily relate to the other, nor are they interdependent: there can be team management without a primary care team and there can be well functioning primary care teams in a traditional, strictly hierarchical management structure.

Since its reorganization in 1974, the British National Health Service, is managed at all administrative levels by teams of officers consisting of a physician, nurse, administrator and finance officer. These teams are by design strictly non-hierarchical, and work on the principle of consensus management requiring unanimity for their decisions. Teamwork at the level of patient care, however, is still sporadic in the United Kingdom.

The non-hierarchical principle can be more readily implemented in

management, where the various disciplines can be said to share responsibility equally, whereas in patient care the physician still retains primary responsibility for the clinical management of his patients even though he may delegate tasks to other professionals. As the boundaries of what is "clinical" become more fluid, however, e.g. between health and personal social care, the services of the nurse, health visitor or social worker assume increasing importance in the management of a case. In the care of elderly, handicapped, and other long-term patients, the transition from active medical to custodial care becomes rather blurred, as does the dividing line between the physician's responsibility and the responsibility of those concerned with the patient's social welfare. Accordingly the latter assume greater and even overriding responsibility for the management of the case, although the physician's role in deciding on the specific course of medical treatment is preserved.

Moreover with advancing specialization other health professionals—dietitians, physiotherapists and other therapists, psychologists, etc.—have come to decide independently on the course of treatment they provide once the patient is referred to them by the physician, or even without such referral.

Managerial, administrative, and financial coordination, while not sufficient in itself, facilitates teamwork at the service level. Teamwork among the providers of service will likewise be facilitated where the members of the team and the agency employing them come under the same administration. In part this is a matter of budgeting, and this can be a help to the centre's financing rather than an impediment to cooperation. Where friction and conflict may arise is in the area of working conditions and, more importantly, in divided accountability. This is the case, for instance, where community nurses employed by the health service are "attached" to independent medical practices rather than being employed by them.

In many European countries particular difficulties are caused by administrative and financial separation between the medical and social services, whereby each side considers its own field as its professional preserve to be jealously guarded against outsiders.

In all these situations, divided record keeping and confidentiality problems can seriously hamper effective patient care. This can at best be mitigated by good personal relationships among team members. In the words of one health centre physician, it did not really matter that he could not see the social worker's records because she could tell him everything that concerned a particular case.

Conclusions

Teamwork in primary care, to be effective, depends largely on the right attitude among the members of the team. This cannot be decreed but it can be supported by such administrative and organizational arrangements as proximity of location, employment by the same agency, compatible conditions of work, joint financing where several agencies are

involved, and reasonable mutual access to records. The most promising approach to establishing the necessary team spirit, however, remains its development by training. The training in each of the disciplines can familiarize trainees with the potential contributions to be made by members of other disciplines or professions. The most effective way of doing this is by joint interdisciplinary training during either basic or advanced training (preferably both), or at least by continuing education of those already engaged in primary care. Many instances exist of such interdisciplinary training in Europe and elsewhere, and a systematic evaluation of the different methods used would be among the most helpful contributions towards ensuring the effective functioning of primary care teams.

Among existing constraints to satisfactory interprofessional relations among team members, the following occur to different degrees in different situations:

Statutory constraints

- —legal responsibility (e.g. concentration on the physician's responsibility and liability)
- —confidentiality of records (especially in regard to health and social service records but also records of other agencies)

Organizational constraints

- —individual team members employed by or working under different auspices
- —different working conditions including method of remuneration for various team members
- —separate funding
- —various administrative levels responsible for certain team members (e.g. local community and regional authority)

Attitudinal constraints (status differences)

- —variation in educational levels
- —variation in length of professional experience
- —age and/or sex differences
- —specialization with insufficient awareness of other disciplines
- —lack of training for work as member of a team

Attempts to overcome these constraints have been observed and described, and in some cases further systematic study seems indicated. On the other hand, many primary care teams in various health care systems function harmoniously and very effectively, either because of the personality of the participants or because of their preparation at some stage of their training. To them this whole discussion will appear unnecessary and academic. For many other places, however, faced with the task of strengthening primary health care, the recommendation of the Thirtieth World Health Assembly still applies, i.e. that Member

States are urged to undertake a comprehensive review of the roles and functions of the different categories of primary care personnel and "particularly the aspects relating to health teams in primary health care, to achieve a satisfactory balance". This is necessary not only for the treatment of the ill, but also for "the promotion and maintenance of health". With special reference to nursing and midwifery personnel, the recommendations further suggest that these and other categories of manpower be involved also in the planning and management of primary health care, as well as in teaching and supervising other primary health care workers (*64*).

It is because of the new demands made on primary care and its extension into the fields of prevention and social care that the work of the erstwhile solo practitioner needs to be more broadly based. The concept of the team, as opposed to a group of professionals working independently from one another, should ensure that the patient and his family are not confronted with a bewildering multiplicity of seemingly uncoordinated professionals or agencies. In the past the general practitioner, practising a less complex medicine in a less complex society, has been able to be all things to all people. In some situations doctors still function that way, effectively filling a need, but the voices advocating this as a desirable state of affairs are rare indeed. A general practitioner in New Zealand may be speaking for a diminishing number of colleagues elsewhere when he describes solo practice as "an important institution for the present and the future", whose place is side by side with health centres "but can never be replaced by them", the reason being that the solo practitioner "is better able to involve the whole family and work-situation than a group of people, who deal with 'bits and pieces' and then have a 'case-conference' to discuss the results" (*65*). This might be true if the practitioner had the time and training to provide adequately all the services provided by members of a team and if the work of the team dealt with "bits and pieces" of a case rather than charting an integrated approach.

To see the primary care team mainly as a device for greater efficiency, e.g. by saving the doctor's time, would be too narrow an assessment. While it has been demonstrated that, for instance, the presence of a nurse can substantially improve a physician's productivity in terms of patients seen, it is only the team which can enable the elderly, handicapped, chronically ill and many acutely ill patients to be cared for by primary care services rather than the hospital. It is the extension of the scope of primary care so as to include the prevention of health and social problems, as well as the solution within the family or community of such problems when they arise, that the team approach becomes necessary and effective. Grenander (*11*) describes how integrated teams can be formed even if their members come from different administrative levels. Thus in Sweden the local municipality, for instance, may contribute social workers and home help leaders; the county council the doctor, nurse and physiotherapist; and the central government local insurance and labour exchange officers.

Since the primary care team is essential if primary care is to meet present and future demands, and since the composition of the team in a particular setting and its functioning are still very much at the developmental stage, its continued international study and observation will be most valuable in helping planners to benefit from the experience of others. At least one journal, *Occupational health and safety*, carries as a regular feature a section on "Teamwork" with practical suggestions for all members of the health and safety team in the United States. This example could well be followed by others concerned with primary care research and literature.

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Range of services

The range of services, staffing patterns and available equipment at health centres and similar forms of primary care organization are, of course, closely interrelated. Which of them determines the others is a matter of the prevailing health policy and the structure of the services. In countries with a public health service (be it national and universal, for certain population groups or, as for example in Turkey, for certain areas) where the range of services has been determined as a matter of policy, staffing and equipment must be suited to provide these services. Similar considerations apply where, in the absence of a health service system or supplementing such a system, public or private organizations establish clinics or dispensaries for certain categories of health problem or narrowly defined population groups; here too the services to be offered will determine the resources necessary to deliver these services. In pluralistic systems, on the other hand, where the form of their organization is left largely to physicians as independent agents, it is their decision first whether to organize themselves in some sort of group or partnership, and second what kind of services should be provided. This is the situation in the countries of central and southern Europe which lack a national health service, although a public sickness insurance system may play a substantial part in financing the services.

Where a unified health service exists primary care facilities, like hospitals, are regionalized, offering a widening range of service as one proceeds from the local level—which may be a health station or dispensary—to the regional polyclinic. Since the availability of personnel and equipment are functions of the resources at the disposal of the health service, so are the services that can be provided.

A further determinant is the social policy underlying a particular health care system. It will form the prevailing concept of health and the boundaries of what the medical services ought to provide. This applies to conditions that only recently became recognized as medical problems and susceptible to medical care. Certain behavioural patterns belong to this category, such as drug addiction and alcoholism, which were formerly matters only for the courts. Family planning services are another example of borderline functions of a primary care organization.

The nature and extent of outreach services and prevention will depend on the principles under which the system operates, and this is partly a function of whether primary care is provided under public or private auspices. Another factor is the degree of community participation; where the community or the consumers of services have a say in the planning and operation of the services, their demands will help to shape the range of services provided for them, and this may well account for the pattern of local services being at variance with national or regional priorities. The introduction of intervention strategies in the course of chronic and degenerative diseases requires outreach services aimed at health maintenance and primary prevention, with a concomitant need for health education services. To the extent that primary care facilities serve as venues for the training of health professionals, provision must be made for training activities to form an integral part of primary care functions.

In some countries health centres assume broader functions than just the provision of medical care. There are various degrees of coordination and integration with the personal social services, as well as with the education system or local industry. Health centres themselves may follow an implicit or explicit policy of providing a source of employment for the community; they may concern themselves with recreation and, as part of their outreach function, participate generally in the social affairs of the community in which they are located. This is apart from health professionals participating individually in community affairs. Where inpatient services exist through the provision of a limited number of beds attached to a health centre, they are usually intended either for very short stay or chronic cases who do not require intensive services and who can thus stay close to their own community.

It will become clear therefore that, while the provision of medical care—diagnostic, curative and rehabilitative—remains the universal and foremost remit of primary care organizations, additional more-or-less remote functions are found in some countries, depending on the social policy governing primary care. The broad areas of primary and potential extended functions of a primary care facility may therefore include:

- primary medical care, including serving as a reference centre for all other health services received by the client population;
- training of health professionals, including all members of the primary care team, as well as epidemiological and other research; and
- active contribution to the physical, mental and social wellbeing of the target population.

The last point is, of course, an extension of the delivery of primary care, but is listed separately because the concept of health maintenance requires a much closer involvement of the primary care facility with the population served, and thus adds a new dimension not only to the structural requirements but also the whole concept of the provision of primary care.

The scope of a health centre in terms of the services provided—staffing as well as equipment—is largely determined by the size and characteristics of the population served. Two trends can be observed here, illustrating by and large an historical evolution. One movement has been to bring primary care as much as possible to peripheral areas, if not by fully-fledged health centres then by sub-centres or nursing or feldsher stations with a minimum of highly trained staff or elaborate equipment. Such facilities serve as outposts for the health care system, with the main objective of providing readily available and accessible first-line services facilitating entry into the system.

Over the decades, increasingly sophisticated and specialized services could be provided only in larger centres. At the same time communications and transport generally improved, so that travel by patients to a centre and by health centre personnel to home-bound patients became easier. Consequently the earlier, widely scattered primary care facilities became consolidated into more elaborate centres strategically located to provide maximum accessibility. This development parallels that in the hospital field, from the small cottage hospital to the district hospital with several hundred beds. The same trend of consolidation can be observed in other community institutions such as schools and churches. The disadvantage of longer travel time for much of the population is now compensated for by the more complete range and quality of service the centres can provide. Spatial distance however, is bound to affect the acceptability of a centre to the population it is intended to serve, and more attention will have to be paid to staff attitudes and the physical design of the centre.

In discussing the range of services provided by primary care facilities in the European Region, the wide variations within countries must be borne in mind. There will be considerable uniformity within those countries that have a tightly structured national health service, as in the socialist countries or in those such as Finland, where health centres are created and operate under national norms. In these countries the service content varies mainly with the level at which a centre functions, ranging in the USSR, for instance, from the local dispensary to the regional polyclinic. Although the United Kingdom has a national health service and a policy of building health centres, this policy is far from being generally implemented. Mainly because of economic constraints, other forms of collective practice are financially supported, such as the improvement of group practices at existing premises. Elsewhere, too, the health centre idea may be officially encouraged but far from generally accepted by the practising physicians, making for a very heterogeneous mixture of forms of collective practice. Sweden has provided a number of strategically located centres offering a wide range of medical and social services. These are being evaluated by the national research organization (SPRI) and university based research institutes. In countries with a large private health sector there may be a number of publicly sponsored centres serving as demonstration projects, or designed to meet the needs of otherwise underserved population groups.

Turkey has its norms for health centres, both general centres and those concerned with maternal and child care, in areas covered by the national health service. France has clinics operated by the social security administration, by the *mutuelles*, and by religious and other private agencies, as well as commune-sponsored health centres. A similar variety of clinics or centres under the auspices of nongovernmental agencies exists in the other European countries with mixed systems. Naturally, the aims and priorities of the sponsoring agency constitute one factor in determining the range of services provided by a particular primary care facility. In the years to come the type and volume of services will be substantially influenced by the new demands on primary care resulting from the move away from inpatient hospital care and emphasis on the importance of health maintenance, self-help, and the implementation of intervention strategies in the field of chronic diseases. The Declaration of Alma-Ata, in Article VII, lists the following services as basic to primary care (*1*): "education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". It should be noted that health education and prevention head the list and that appropriate treatment of disease and injury follows the various preventive activities. The provision of appropriate treatment must obviously be shared by primary care with other levels of care, but the priority implications for primary care are clear. It is also clear that the new and broadened concept of primary care calls for intersectoral collaboration (*2*), rendering the boundaries between health (or medical) services and other community services fluid and no longer susceptible to the traditional compartmentalization of the various service sectors in the community.

Primary medical care services

The common core content of primary medical care provided by the various organizational forms existing in the countries of Europe consists of (*a*) diagnosis and (*b*) treatment or referral. Diagnosis also may require referral, but just for diagnostic purposes, to another facility where the appropriate equipment and expertise are available.

It is in the area of prevention and outreach that the range of services differs among countries and individual primary care facilities. To some extent it is the outlook of the individual practitioner that determines whether or how far he is motivated to move in either of these directions. His outlook will be influenced by his personal philosophy, but also by his training and the incentives or disincentives inherent in the way he is remunerated. Fee schedules of insurance programmes, for instance, are often constructed in such a way that they tend to give greater weight to

therapeutic procedures and the use of equipment than to consultations, which do not involve medical technology. This has become a major concern in countries with mixed systems in the wake of policies of cost containment.

The different forms of primary health care organization, often found within the same country, can be grouped at four levels.

1. The polyclinic type with multispecialty medical staffing, where patients have direct access not only to the general practitioner but also to most, if not all, the specialties represented at the clinic.

2. The centre staffed by one or more general practitioners, together with other members of the primary care team such as nurses, social workers, therapists or technicians for the operation of diagnostic or therapeutic equipment, as well as the required administrative personnel.

3. The dispensary type of centre, with similar staff to those providing general primary care but directed only towards the care of specified conditions or groups of patients.

4. The station or centre providing only back-up services such as nursing and/or social services on referral by general practitioners. The latter are in free-standing practice in the community without being either physically or administratively tied to the centre. Examples are the *Sozialstationen* in the Federal Republic of Germany.

Diagnostic X-ray or laboratory equipment and the corresponding staff may be provided either within the primary care facility itself, or at a central centre or hospital, or in a free-standing facility, possibly in the form of a laboratory common to several general practices. In regard to the employment of a clinical pharmacist in a health centre, a working group (*3*) found such an appointment justified in centres "with a large medical staff"; otherwise these services may be provided by the pharmacy in the district hospital or, as in many of the European countries, by a free-standing pharmacy.

Among the many roots from which the health centre idea has grown, there are perhaps two philosophies that can be identified as the main underlying determinants—one stemming from considerations of rationalizing an increasingly complex and otherwise fragmentary array of resources to provide an effective and efficient medical service; the other prompted by the desire to provide people with a focal point emphasizing health maintenance and prevention while still providing the necessary medical care. These two objectives are closely related and many of the centres existing in Europe combine both elements. One may expect the health maintenance and preventive aspects to gain in importance with the growing emphasis on preventing chronic diseases and with the implementation of the Alma-Ata philosophy.

This form of organization provides the closest possible approach to the aim of a one-stop medical service, and at the same time improves the quality of the service by contact among the professionals as well as by more and better equipment. One frequent criticism is that, as the size of

an institution and perhaps also its geographic remoteness increases, it becomes more impersonal and thus interferes with the desired doctor–patient relationship, the effectiveness of health education, and compliance with a prescribed regimen. There is, however, no need for a health centre to be impersonal.

The most important factor in preventing an institution from developing a forbidding air *vis-à-vis* its patients is the attitude and demeanour of the staff with whom the patient comes in contact, from the receptionist to the attending physician. The receptionist is probably the key person in this respect, since he or she is the first person encountered and therefore sets the tone. Children are particularly easily impressed either way. A friendly reception does not cost more than a cold, business-like one, be it in a large centre or a solo practice.

While personal attitudes are most important, the design of the premises can also contribute to creating the right atmosphere. This applies, to begin with, to the outer appearance of a building, but more so to the interior layout, especially of waiting rooms. Whether such waiting rooms should encourage patients to socialize, and thus provide an added incentive for people to come, depends on the cultural setting. Small groups of seats create a friendlier atmosphere than parallel rows of chairs all facing one direction. However, where an appointment system works effectively, thus minimizing the waiting time, the design of the waiting room can be more functional.

In general, health centre staff think it desirable that patients should be seen by the same doctor each time they attend. This, it is felt, renders the service more personal and enables the doctor to know the patient and his circumstances, especially where family care is involved. In some instances, however, where staffing is poor in relation to the demand for services, it appears more important for patients to see any doctor at the centre at short notice, rather than having to wait longer for an appointment with their personal physician. In such cases, respondents in a survey would give as their regular source of care the name of a clinic or centre rather than that of a particular doctor. Such an arrangement, of course, is contingent on a central record file. Patients' attitudes towards seeing the same doctor may vary with their background or past experience. A study in Scotland[a] reported that older patients were more likely than younger ones to see the same doctor, but the report does not indicate whether this was due to the patients' preference or the administrative practice at the centre. With the development of the primary care team, including doctor, nurse, social worker and possibly other professionals, the question of personal care for an individual patient or his family extends from the physician to the team. An effective team approach, including case conferences, would be difficult to carry out unless the patient or his family were known to all members of the team. In these situations medical care merges with social care and

[a] Brand, J., unpublished data.

other community services that bear on the preservation of health and the care and rehabilitation of the sick, as pointed out in the Declaration of Alma-Ata.

The variety of staffing and hence services provided by various organizational forms of primary health care also blurs the borders between primary and other levels of care. Some specialties such as internal medicine, paediatrics, gynaecology and obstetrics are becoming part and parcel of primary care. Other specialties are represented in the various types of polyclinics existing in European countries, similar to the multi-specialty group practices in North America, and the patient may have direct access to these. Provision for minor surgery exists in many health centres, except local ones. With the financial pressures on the general hospitals, day surgery is becoming more prevalent and, as the trend continues, may lead to the establishment of independently operated ambulatory surgical centres. In the United States context, these centres have been described as presenting a continuous challenge to hospitals (*4*) and they shift an important part of what has traditionally been regarded as secondary, institutional care into the community and the primary sector.

The attachment of beds to health centres for inpatient care, rather than only temporary emergency accommodation, is another step towards greater integration of institutional care into the community. It is to be hoped that this will gradually erode the notion that the hospital is, or should be, something distinct and separate from the community. Such beds may be used for short-term observation, diagnosis (as for example in some polyclinics in France) or normal confinements as in Bulgaria and some other countries. On the other hand, general practice beds attached to the centres in Finland and Portugal serve short-stay, acute cases as well as patients with chronic conditions requiring a minimum of acute care.

Hospitals for their part are, albeit very cautiously, moving beyond their four walls and into the "community", by making some of their staff and certain types of equipment available to selected patients in their homes. The criteria for selecting patients for this "hospital-at-home" service are that there is no need for continuous nursing or for the use of highly sophisticated equipment. Such a service may serve either to avoid the need for admission to a hospital or enable earlier discharge of patients. Such arrangements have been in operation for many years in Canada and the United States, where they have been known as "organized home care", often operated by private, non-profit visiting nurses' associations. Day or night care at the hospital, temporary discharge (such as for holidays or weekends), or temporary admission (for example to relieve other members of the household from caring for a patient) are other instances of breaking down the barriers between care in the hospital and in the community at large.

As a result of developments towards increasingly comprehensive services at primary care facilities, the traditional distinctions between primary, secondary and tertiary care are beginning to lose their

meaning. Neither the need for a bed nor the degree of specialization any longer provide criteria for distinguishing between levels of care. To the extent that hierarchical levels will exist in this regrouping of resources, they will be determined rather by criteria for regionalization, i.e. the different population bases required for the effective deployment of specialized personnel, facilities, or equipment. As far back as 1973, a report issued by the Council of Europe on the future organization of medical practice (*5*) described the health centre movement as follows:

> A health centre will be housed in a building where a wide range of primary care is provided. The usual group-practice staff—general practitioner, secretaries, receptionists, nurses, social workers—will be supplemented by specialists and sometimes by public health doctors who come and provide out-patient services at such centres. They may be specialists in any discipline but will mainly be paediatricians, gynaecologists, psychiatrists and geriatricians. Most of the centres have advanced facilities: X-ray and physiotherapy apparatus, function-testing equipment and laboratories. They thus provide doctors working there with an opportunity to make the fullest use of their skills.

The trend towards greater comprehensiveness at the first access level of health care is happening throughout the world and reflects the discussions at Alma-Ata, where primary care was seen as essential care, exercising the central function and representing the main focus of a country's health system. A more recent policy statement by the American Public Health Association (*6*) advocated increasing the range of services and creating more combined medical groups "to provide services comprehensively in one location". These developments depend, however, on effective overall planning if costly duplication or gaps in the equitable provision of services are to be avoided.

Noting the variety of medical services existing in health centres in most European countries, one can best review the range of these services by looking at predominent patterns rather than the exceptional experimental or demonstration project. This approach will be facilitated by examining similarities or differences within three broad groups of health care system without, however, implying a great degree of homogeneity within each. The three groups are:

— the health care systems in the socialist countries;
— those in largely private enterprise or mixed economies but with a national health service; and
— the pluralistic systems in Europe with varying degrees of coverage by some form of sickness insurance.

The socialist countries of eastern Europe

While considerable differences exist in the health care systems of these countries (resulting, for example, from different degrees of industrialization, varying topographical features and degrees of urbanization, the extent to which private practice is tolerated and regulated, or the

balance between centralization and decentralization) the health services are patterned largely on those of the USSR. It was in that country that a socialist order was first established in 1917, and a health service designed to fit into the framework of a planned economy. It is there that the right to health protection is enshrined in the constitution.

Apart from the small private sector, where it exists, these systems are strictly regionalized and have therefore developed a hierarchy of primary care institutions, ranging from the peripheral station to the central polyclinic. Under such a system, as mentioned earlier, it is national policy that determines the range of services to be provided and consequently the kind, quantity and distribution of resources to be made available to deliver those services. Policy regarding the nature of services to be provided is made explicit at several levels. First, in the USSR and other socialist countries the constitution proclaims the citizens' right to health protection. This general principle is elaborated on in Article 42 of the USSR Constitution, for instance, by identifying broad areas of health protection such as free medical attention, extension of the network of health facilities, safety and hygiene at the place of work, extensive prophylactic measures, protection of the environment, special attention to the health of children and young people, and finally research on the prevention and control of sickness and procurement of a long and active life.

Under federal constitutions such as those of the USSR and Yugoslavia, there is legislation setting out the respective authority in health matters of the federal and republic legislative agencies. In Yugoslavia decentralization is taken further by granting a high degree of autonomy to individual health institutions, albeit with a system of checks and balances within the framework of general local, regional and central planning. Federal health legislation in the USSR enumerates the areas to be covered in the following order: prevention, especially among the young; health and safety at work; protection of the environment; development of the network of health facilities; and provision of free medical services. The federal legislation further specifies the last of these by including specialized medical assistance, emergency and domiciliary aid in outpatient departments, and specialized follow-up centres; it also describes in broad terms the diagnostic and therapeutic methods to be used. In the German Democratic Republic resolutions of successive congresses of the Socialist Unity Party also emphasize the importance of prophylactic measures, including health education, in addition to the extension of health care facilities (*7*).

Among the characteristics of these systems is the existence of several parallel streams of health care. Besides the personnel and facilities serving the general population of a defined area, there is the industrial health service, programmes for the care of mothers and children, and the dispensary or follow-up services aimed at certain health problems or population groups. Here, as in other countries, the armed forces maintain their own services for their members, and sometimes for dependants. In addition there are the sanitation and epidemiological centres providing

support services such as surveillance and monitoring of statistical and epidemiological data, laboratory testing, and general education in hygiene. In the USSR some small rural communities are served by feldsher–midwife posts. These perform three basic types of work: application of sanitary and anti-epidemic measures, health education and organization of public participation in the prevention of disease, and curative and preventive care, the latter under the authority of the senior physician of the rural district hospital (*8*). The midwife is responsible for antenatal care and postnatal supervision, but deliveries take place in hospital.

Recent health policy in the USSR, even before the Alma-Ata Conference, has been directed towards the expansion of the dispensary type of health protection to cover the whole population. The care thus provided has been described as "an active method of dynamic follow-up of the health of certain groups of healthy and sick citizens with the aim of early detecting diseases, of putting under observation these groups of population, of the dynamic checking and the complex treatment of sick subjects, of the carrying out of measures pursuing the improvement of working and living conditions, of the prevention of appearance and spreading of disease, of the maintenance and strengthening of the working capacity" (*9*). In short, the aim has been to bring high-risk groups and patients suffering from certain diseases under continuing surveillance or follow-up. The same authors quote an earlier report (*10*) as saying that in 1975 dispensary care was available to 15% of the adult population covered by polyclinics, while 50–70% of industrial workers were so covered.

One aspect of community care is the extent of home visits made by physicians. Based on USSR statistics for 1969 reported by Popov (*11*), home visits as a percentage of total consultations by physicians in selected specialties were as follows:

	Urban areas	*Rural areas*
Internists	14%	4%
General practitioners	–	10%
Učastok paediatricians	31%	41%

The combined figures for internists and general practitioners show equal proportions of home visits in urban and rural areas. Učastok paediatricians, on the other hand, made a higher proportion of home visits in rural areas. Popov is cautious regarding the advisability of home visits and the use of the "home-hospital" programme; indeed the practice of home visits has declined sharply in most countries. The development of the primary care team, however, will increase the potential for home care by a member of the team.

The practice of home visits, especially in the paediatric sector, is referred to by the Bulgarian Ministry of Public Health. House calls are also part of the general practitioner's work in Hungary, where they may constitute a heavy burden in some rural areas. One general practitioner reported seeing an average of 7–8 bedridden patients in their homes

each day. In Poland, about 6% of general practitioners' consultations take place in the patient's home, and it is felt that more home care may be required for the chronically sick. House calls by general practitioners are described as part of the dispensary care in Romania. The health ministries in Bulgaria, Czechoslovakia, Hungary, Poland and Romania, in describing their primary care organization, also emphasize prophylactic services. With a high degree of similarity in this respect, the countries draw attention to particular aspects seen as important under prevailing circumstances.

Bulgaria stresses the priority of services to children and young people, pregnant women and mothers, and industrial workers. The health sector physician, i.e. the local general practitioner, combines diagnostic and therapeutic, prophylactic, and sanitary and anti-epidemic functions. His health education activities aim at marshalling community participation in the solution of health problems.

In Czechoslovakia, primary care also concerns itself with health education as well as with social problems and care of the family.

The general practitioner in Hungary is also considered the family doctor; he may advise on family planning and marriage, although counselling services exist in the larger towns. Ambulance services are organized nationally, but are available locally. Health education is provided through lectures, films, nutrition counselling, clubs for the young, posters and other health educational material; voluntary organizations such as the Red Cross and the Pioneers help with health visiting. In one rural practice, as an example, one day a week is set aside for voluntary screening of people over 40 years of age; screening for cancer of the breast and uterus is offered to women over 30 or 35, and for cancer of the prostate to men. Schoolchildren have annual dental checks.

Characteristic of the primary care services in Poland is the integration of the health and personal social services, and the coordination of medical and social rehabilitation.

Romania also stresses prophylaxis in describing the range of services provided by primary care facilities in addition to diagnostic and therapeutic activities, as well as surveillance of health in the community. Stomatological services, which include prevention, concentrate on children, young people and the working population, being extended to other groups in accordance with available resources.

One of the several streams of primary health care in the socialist countries is the occupational health service, which differs from the services provided in other European countries. In the latter industrial health measures are largely confined to identifying and controlling specific hazards to health and safety at the place of work, whereas in the socialist countries occupational health personnel also attend to the general health of the employees unless they are homebound, when they come under the care of the general practitioner or specialist in whose area they reside. This division of responsibility for the health of various population groups, and specifically of industrial workers, can be traced

to the origins of socialist health systems in the early days following the socialist revolution, when the priorities were maintaining the health of the armed forces, of the workers (whose productivity was critical) and of mothers and children. Today this may be regarded as fragmentation and against the principle of the holistic approach to the care of the individual and the family; on the other hand, each group of patients can profit from the more specialized care. In the case of industrial health care it can be said that if factory workers were attended by their own doctors, any health hazard common to them might not be detected. Furthermore, the industrial physician in the socialist systems forms a direct, and therefore possibly more effective, link between the personal care of the employees and protection of the working environment. Also, it is increasingly becoming recognized in all countries that modern industrial hazards are not confined to specific toxic substances or hazardous procedures, but include such elusive factors as stress, the effects of shiftwork, and others that affect general health. Detrimental fragmentation or duplication of services on the one hand, and gaps on the other, can be avoided only by close coordination between the industrial and general health services. This implies adequate consultation and an effective record system in which the various strands of service for the same person or family converge.

Other European countries with a national health service

This group includes the mixed-economy countries of Scandinavia, Iceland and the United Kingdom, which have public health service systems as distinct from systems providing some form of public or private financing of largely private sector health resources. Some other countries in Europe are also introducing national health services.

These systems have certain important elements in common with those of the socialist countries, i.e. central health policy-making and planning (albeit in the absence of central economic planning) together with public ownership of health facilities and employment of personnel. In some countries certain categories of personnel (for example general practitioners, dentists and pharmacists in the United Kingdom) may formally maintain their status as independent contractors, but contracting with the state system collectively through their professional organizations. These systems too are regionalized in regard to the distribution of health resources.

Among the major differences from the socialist systems is the unified provision of personal health services rather than the separation of, for instance, occupational health services or maternal and child care; the pros and cons of this have been discussed above. There is, in general, less emphasis on outreach activities than there is in the socialist countries, especially in their dispensary activities, although some clinics for specific diseases and registers for the follow-up of certain patient groups do exist here and there.

The range of diagnostic, therapeutic and remedial services provided in primary care is very similar to that in the socialist countries; the organization of these services, however, is not as systematically and hierarchically structured. The provision of health centres with their primary care teams is declared policy but is not universally implemented. Finland, following the legislation of 1972, comes close to it, at least in the areas outside the larger cities. The personal social services are integrated with the health services to different degrees, even within countries.

These general observations, however, must be qualified for individual countries, and here again health ministries emphasize different aspects of their primary care system.

Iceland places great emphasis on its preventive programmes, including those directed at mothers and children, school health, sports and industrial medicine, the prevention of tuberculosis and sexually transmitted diseases, and mass screening programmes for cervical cancer, diabetes, heart disease, eye and ear diseases, etc. This outreach is declared to be one of the main orientations of the system, and it includes health educational activities as among the duties of health centres. Family planning has been part of the duties of the medical officer of health since legislation was introduced in 1935. These duties were broadened in 1975 to include sex education and counselling and advice on termination of pregnancy and sterilization. The new legislation stipulates every person's right to counselling and education on sex and childbirth, under the general supervision of the Chief Medical Officer, to be provided by physicians, social counsellors, midwives, nurses and teachers as required. The assistance should be given in the form of (*a*) education and counselling on the use of contraceptives and how to obtain them, (*b*) counselling for persons intending to undergo a pregnancy termination or sterilization, (*c*) sex education and counselling and education on the responsibilities of parenthood, and (*d*) counselling and education concerning the assistance available to women in connection with pregnancy and childbirth. These services are to be provided in health centres as well as hospitals and, as appropriate, in conjunction with other interested community agencies.

While prevention may be clear government policy, implementation often lags badly behind as, for example, in the United Kingdom. This is partly a matter of implementing new policies and partly also of making the necessary resources available at a time of financial constraint, even though prevention may mean long-term savings. Thus the Republic of Ireland makes it clear that in future greater emphasis is to be placed on the preventive rather than the medical care content of primary care. In newly created health centres, therefore, the trend is for the provision of preventive services with less stress on the traditional medical services. However, in some areas the general practitioner services are still below standard and must be upgraded.

Similarly, in Finland the implementation of the health centre programme has facilitated not only the extension of the therapeutic

services, such as physiotherapy, but also the systematic application of preventive measures including health and nutrition education; dental prophylaxis for children, pregnant women and diabetics; clinics for adolescents; family planning; and screening for certain critical age groups. The frequency of periodic health examinations and the population groups selected (and probably also the staffing of a particular centre) vary according to local resources.

Such health centres as exist in the United Kingdom also see health education as one of their functions, in addition to the standard medical services. But health centres differ in the range of services they provide. The government considers that putting all the facilities into all health centres would be neither practical nor necessary and would be wasteful of manpower and equipment. A recent Royal Commission (*12*) found that, although not every health centre provides all these services, they usually include preventive services for pregnant women, preschool children and schoolchildren, and health education and family planning. Supporting social services are also usually provided. Furthermore, in the United Kingdom, preventive activities in primary care are to a large degree carried out by the health visitor, a qualified nurse with special training in health education and other preventive measures.

Traditionally, the main work of the health visitor has been maternal and child care, but the increasing health needs of an aging population have meant additional tasks. These have been identified in general terms (*13*) as searching for, identifying and evaluating health needs and motivating clients to deal with them. Specifically, there should be screening of the well elderly, particularly those aged over 80 years, and surveillance of high-risk groups among the elderly, i.e. those living alone, those recently bereaved, those with locomotor difficulties, those showing signs of mental impairment, those recently discharged from hospital, and those tending to isolate themselves.

Overall policy in the United Kingdom is for health centres to provide any or all of the following services, depending on size and location: general medical, dental, pharmaceutical and ophthalmic services; nursing; health visiting; chiropody; health education; teaching; specialist consultation; physiotherapy, speech and occupational therapy; laboratory services; and diagnostic radiology.

Sweden, as in some socialist systems, has a number of special maternity health centres, sometimes connected with the obstetric department of a hospital, and there are special child health centres operated by county councils and connected to paediatric hospital clinics. Here then is another example of combining prevention and therapeutics for specific groups of patients in one facility.

The Scottish Home and Health Department, in outlining its health centre programme, lists the range of services and facilities to be provided by health centres. Apart from general medical services, the list specifies the following preventive and therapeutic activities: treatment room services (treatment of minor wounds, dressings, immunizations, therapeutic injections, and other therapeutic procedures such as ear

syringing and special treatment for varicose ulcers); certain diagnostic procedures such as venepuncture and cervical cytology; laboratory services (haematological, biochemical and microscopical investigations); diagnostic radiology (most economical in urban areas serving more than 25 000 people, but also in some isolated centres); ECG services (in centres of any size); medical rehabilitation; occupational therapy (in larger centres); chiropody for the elderly and disabled; speech therapy (not yet generally provided but to be considered); and various types of social work (mental and physical illness and handicap, marital and family problems, financial and housing problems, needs of the elderly, bereavement, child care, delinquency and truancy, unwanted pregnancy). General dental services are said to be difficult to organize, except for services for children and pregnant women. Health education should be directed at health promotion and disease prevention, and should include sex education.

Various arrangements exist in these countries for service outside regular hours. Where clinics or centres are not professionally staffed around the clock, there may at least be a telephone answering service to contact doctors or nurses on call. A less satisfactory substitute is the deputizing service, which may be operated commercially subject to certain licensing provisions. Alternatively, doctors may do out-of-hours work on a contractual basis for groups of practitioners in a given area.

The "hospital-at-home" idea is still very much in the experimental stage in the countries of the type under discussion. The two dimensions yet to be fully evaluated are the interest of the patient and his family, and the cost–benefit equation from the point of view of both the health service and the client, as well as other potentially involved community agencies.

A link between primary and secondary care is established where beds for inpatient care are attached to health centres as they are, for instance, in Finland and Portugal. These beds may be intended for the acutely ill with but a few days stay, or the chronically ill requiring a minimum of care and who can thus be cared for near their home. In the Finnish situation it is suggested that health centres have a ward of about 30 beds for acutely ill patients and about 60 for the chronically sick (*14*).

Local disasters, which seem to be increasing in scale and frequency with growing industrialization, put increasing demands not only on the organized emergency services—mainly hospitals and ambulance services—but also on the general medical services. The latter are likely to be more heavily and more directly involved in emergencies in isolated areas away from the concentration of health facilities in the larger centres. This was made clear in the wake of an industrial explosion in Finland, where the importance of maintaining adequate communications was stressed, as well as the need for training health staff to act in such situations: "the further away from a large centre that serious accidents occur, the more important it is that primary care teams know what to do" (*15*).

Pluralistic health care systems

The health care systems in this group of countries are characterized by their resources coming largely from the private sector, operating under a multiplicity of auspices but financed to different degrees through public or private insurance arrangements. As far as the range of primary care services is concerned, it is important to bear in mind that under these circumstances individual professionals or institutions are in general not committed to a defined population. The exceptions are institutions sponsored by groups, such as public employees, to care for their members. Where this is not the case, however, there is still opportunity or incentive for the kind of outreach that exists under national health service systems directed at health maintenance, prevention and health education, or surveillance and follow-up, except on a one-to-one basis.

The establishment of the Peckham centre in London before the Second World War remained a relatively short-lived experiment, but similar isolated projects do exist. One of these is a "health shop" established by a Dutch doctor and physiotherapist which, for a neighbourhood in Utrecht provides discussion groups and courses on health problems, making people aware of what they themselves can do about their health (*16*). Most countries, however, have retained in some form or other the institutions of the traditional public health services, concerned largely with diagnosis and case-finding, but also providing dispensary-type treatment for selected diseases such as cancer, tuberculosis, sexually transmitted diseases and addictions. These facilities are generally used by the poorer sections of the population. Where public services are aimed at case-finding and diagnosis, positive results are usually referred to the patient's own physician. Occasionally, in otherwise underserved areas, such facilities will provide comprehensive services, as do the "polyvalent" clinics in France.

Ministerial policy in these countries is generally favourable towards the structured organization of primary care in the form of health centres, and legal obstacles to the collective practice of medicine are gradually being removed. However, the choice of whether to combine their practice with others, and if so in what form, is left to individual practitioners, who consequently determine the range of services they provide. It is not surprising, therefore, that a great variety of organizational forms and corresponding services exist in these pluralistic systems although, owing to common traditions, legislative frameworks and the social environment, certain similarities exist within these countries.

In the Federal Republic of Germany the various forms of medical group practice, supported by either free-standing or pooled laboratory services, provide the full range of ambulatory diagnostic and therapeutic services. Additional support through the provision of domiciliary care and certain social services is offered in the so-called "centres for social assistance" (*Sozialstationen* or *Sozialzentren*). Legislation in one of the states specifies the services provided by these centres as including home

medical care, care for the aged, family services, meals-on-wheels at midday, an advisory service for the aged, health education, staff training, and related services. For other social services the centres should refer people to, for example, the social service departments, public health agencies, sickness insurance offices and other public or private advisory services. The guidelines add that professional services provided by the centres shall be limited to the areas of competence of the staff (*17*). Some centres also provide ambulatory care and hire out equipment. These are facilities to which local physicians, mostly general practitioners, can refer patients, without being on the staff of the centre. The centres may be open only 8 hours a day, 5 days a week, in which case there is a 24-hour emergency telephone service with a doctor always on call.

In France, too, there are various groupings of physicians in the private sector who, depending on the specialties represented, provide the usual range of medical services. In addition, there are centres operated for the care of their members, i.e. the *mutuelles*, those that operate under the auspices of the social security agency or of religious or other charitable organizations, and those established and supported by local communities. Multi-specialty clinics of the *mutuelles* may have beds attached for adult patients, but these are generally for diagnostic tests and not for treatment, and are only for short stays (up to 6 or 7 days). For certain special services not available at a particular clinic, arrangements may be made with other polyclinics. Consultations are by appointment, and where a patient has to visit several parts of the clinic this is arranged for the same day or half day as required. There is always a doctor in attendance at night, and there is a permanent office where medicosocial advice can be obtained. Centres under the auspices of the social security agency in larger cities may, in addition to general practitioners, offer several dozen specialties, with such support services as laboratories, radiology, endoscopy, electrocardiography and encephalography, as well as remedial facilities including physiotherapy and orthophony. Social services are available when needed, especially for patients with financial problems.

In the larger cities of France there are also public dental care centres, especially in otherwise deprived neighbourhoods, specializing in dental care for children, including prophylactic, therapeutic and restorative care with the appropriate laboratory facilities. In many cases the populations served by these centres have a large proportion of immigrants, mostly people who would find it difficult to pay for private care. Health education and prophylaxis are generally poor in these areas: when parents are asked to bring their children for check-ups, only about one in five respond. Drinking-water is not fluoridated; topical fluoridation is available but is used judiciously so as not to encourage neglect of other forms of dental hygiene. The services are accessible to all residents but are, in practice, used mostly by those with modest means. Maternal and child health centres give high priority to preventive care; some in the Paris region provide quite extensive periodic examinations, taking 2–3

hours, for children at the ages of 10 months, 2 years and 4 years. The results of these examinations are passed on to the child's attending physician or clinic. France also has publicly sponsored dispensaries aimed mainly at preventing and detecting specific problems such as tuberculosis, sexually transmitted diseases, cancer and mental disorders. Some local communities in France, especially among those with socialist administrations, maintain primary care centres for the resident population.

Similarly heterogeneous are the forms of primary care organization and the services provided by them in other countries of central and western Europe. The health ministries in these countries can, therefore, at best provide a general overview of the aims and activities of such centres or clinics as exist.

Health centres in Belgium aim at providing all the diagnostic and curative primary care services, including those required for particularly prevalent diseases such as diabetes. Primary prevention is practised through health education, printed material, press releases and meetings. Immunization is provided on an individual basis and is not considered a collective responsibility. Screening for cancer in women is widely practised, as is surveillance of hypertensive patients. Physiotherapy is usually available. Psychological help and psychiatric care are generally confined to urban areas. Marital and legal counselling are as yet little available, but the need for these services in the context of primary care is increasingly recognized and there is a growing demand, especially in urban industrial areas.

In the Netherlands services provided by health centres are those of the general practitioner, the district nurse and frequently also the social worker. In addition, almost two thirds of the centres also provide physiotherapy, and about one in five offer the services of midwives, home helps, dentists, dietitians and auxiliary district nurses. Some centres may provide the services of pharmacists, nurses for the elderly, psychologists, social counsellors, priests or occupational therapists.

Among the desiderata in the planning of a suburban health centre in the Republic of Ireland are: general practitioner services; developmental paediatrics, child welfare and antenatal examinations; psychiatric, ear, nose and throat, orthopaedic, ophthalmic, immunization and BCG clinics; dental care; preventive public health nursing; social services; home help; income maintenance; such supportive services as physiotherapy, chiropody, speech therapy, audiometry and developmental psychology; and health surveillance. These services and facilities would be scaled down in centres serving smaller populations.

The services of the medicosocial centres in the Swiss Canton of Vaud resemble those of the "centres for social assistance" in the Federal Republic of Germany. They cover home nursing, social services and home help. They collaborate with both public and private agencies, support family services and those for the aged, and develop home help services. They carry out preventive activities, including screening and health education, and participate in school health services. All these

activities are designed to avoid or postpone hospitalization or reduce the length of stay.

In Greece various centres, both fixed and mobile, provide maternal and child health services, including dental services for children, and there are facilities for mentally retarded children.

Certain medically deprived areas in Turkey, especially villages in rural areas, are served by government-operated health centres (*ocaks*) whose primary objective is prevention, complemented by curative medicine. An important task is health education and environmental protection. Services for women include marriage counselling, ante- and post-natal care, and family planning. Protection of the child includes examination of the newborn and surveillance, information on feeding, physical and mental development, prevention of illness in infants, vaccination, and accident prevention. Dental care and dental hygiene are provided for mothers and children, as is general health education. In areas where general medical care is provided by professionals in the private sector, the *ocaks* are largely concerned with the disabled, communicable disease control, and protection of the environment.

Many of the countries in the Region are experimenting with "hospital-at-home" programmes, i.e. the provision of professional and technical services and equipment to patients in their own homes, provided that they do not require continuous service or supervision and that the home is suitable. This requires careful selection of patients with regard to their own needs and the possible effect on those caring for them. Whether such arrangements save money, depends on the individual case. Comparative costing must take into account not only cost to the hospital and the health service, but also both direct and indirect costs to the patient and his family.

Training functions

Since about 80–90% of all health problems are dealt with at the primary level, it stands to reason that professionals should receive adequate training in that kind of care. Training must, however, allow for the fact that the more severe conditions treated in hospital, and the technical skills required there demand more input than would be indicated merely by the number of cases.

Health centres are in a unique position to provide opportunities for training in primary care since they have the necessary facilities. This applies to the undergraduate, vocational, and continuing training of physicians, nurses, and other members of the primary care team. Centres in outlying areas can also serve to familiarize health professionals with the health needs of rural populations, and motivate at least some of the trainees to practise in these areas. Vocational training for general practice in the United Kingdom consists of a year as trainee practitioner in a teaching practice approved by the Regional Postgraduate Education Committee. In addition to the undergraduate and vocational training of physicians, professional staff of primary health care centres participate

widely in the education and training of nurses undertaking post-basic training in district nursing and health visiting, as well as in the training of student nurses.

Exposing students and trainees in the various health professions to teamwork is critically important for the future of primary care. It is generally recognized that collaboration among several categories of personnel is essential to the modern concept of primary care, and teamwork implies mutual appreciation of one another's potential contribution and recognition of boundaries of competence, authority and responsibility. Where this awareness exists, the question of the team's hierarchical or non-hierarchical organization becomes largely academic. Exposure to teamwork is often provided for those already qualified and practising their respective vocation; but by that time they have come to see the world only from the point of view of the discipline they were trained in, with consequently little knowledge of and regard for the potential contributions of others.

In the hospital setting the presence of students and trainees among the attending staff has become generally accepted by patients as part and parcel of hospital routine (perhaps due in part to the more passive condition of the horizontal patient). It appears that in national health service systems also, the presence of trainees in primary care facilities has raised no adverse reaction from patients. In the United States, however, the question has been raised of community acceptance of students in health centres and group practices and conceivably similar problems could arise in certain situations in the European Region, depending on the degree of community involvement in the centre's operation. In fact, some years ago, most private group practices in the United States were said to be unwilling to accept students, partly perhaps because of patient resistance (real or imagined), but perhaps partly because of the cost involved in providing training (*18*).

The primary care facility and the community

Some aspects of the operational interface between a primary care facility and the population it serves are discussed in Chapter 8. Briefly outlined here are certain adjustments made or to be made by the providers of primary care to bring about some liaison with health-specific as well as general community development, while bearing in mind the need to remain part of the referral system within the various levels of health care delivery.

In common with all citizens, doctors and other health professionals have a stake in their community and a role to play in its affairs. Many actually take a very active role as elected or *ex officio* members on local boards or regional or national legislative bodies. The position of the industrial physician in the socialist countries of Europe renders him an effective link between primary health care and the environment in which his patients work. Medical officers of health have often taken a leading

role in bringing about community action to improve housing and sanitation, and generally to combat the consequences of poverty and ignorance. The same is true of some individual practitioners. In all industrialized countries, doctors employed by industry or responsible for inspection of the industrial environment have been concerned with improvements within that limited area but, with some exceptions, without being involved in the personal care of those employed in the industries concerned. It has been argued that the physician, perhaps more than other members of the community, has the opportunity and responsibility to take an interest in the affairs of the community and its development, because of his intimate knowledge of the human condition (*19*). Be that as it may, the new concept of primary care, when it calls for coordination among different ministries and recommends that national health policies and plans take full account of the inputs of other sectors bearing on health (*1*), is dealing with the institution of primary care rather than its individual practitioners. There is as yet little evidence of effective coordination at such high levels of policy-making, although attempts are being made to form committees of cabinet members responsible for the government departments most directly affecting people's personal health. Such a committee was created in the United Kingdom, but little more was heard of it. It is still largely true that while a health ministry may identify health hazards, other ministries may encourage the production and sale of hazardous goods. Therefore, any direct involvement of primary care with community development remains on the whole restricted to the local level. In many countries the concept of the primary care team now includes social workers, usually employed by and responsible to the local authority. The outreach activities of health centres have been described above. Originally limited to case-finding and follow-up, these activities are increasingly directed towards health maintenance, primary prevention, and the expansion of health educational activities to serve those purposes. Primary health care services are increasingly aiming at achieving healthy lifestyles among the populations they serve.

Outreach means a change in the basic stance of the medical services: no longer are they merely waiting for people to come to them, but they take the initiative in taking their knowledge and skills to the population they serve. Such activities imply that the primary care facility assumes responsibility for a defined population which, where the health resources lie in the private sector, is usually not the case. The definition of the target population may be in geographical terms, as in countries with strictly regionalized health systems; it may relate to members, such as those of the *mutuelles* in France or those of the health club that formed the clientele of the early Peckham experiment in London; or it may consist of patients who have visited a clinic or centre and whose records are maintained there for possible follow-up.

The possibilities of outreach cover a wide spectrum, from health maintenance of general populations, through primary prevention among specific risk groups, to secondary prevention through follow-up. "Patient

clubs" such as those described in Croatia (*20*) have also been in existence for many years in other European countries. One particular group chosen for that kind of follow-up are those with hypertension. In Zagreb, for instance, hypertensive patients under medical treatment have formed clubs where they meet regularly to take each other's blood pressure and keep individual records; they receive some help and supervision from health workers.

Incorporating the social worker into the primary care team has become widespread practice in the European Region, and there are instances of other occupations being drawn into the health service sphere. Marriage counsellors, lawyers, and members of the clergy have been mentioned; the postman in rural Sweden helps to maintain contact with elderly people and other risk groups, a function occasionally assumed by the milkman in the United Kingdom. Some countries have established independent agencies to promote health education, such as the Health Education Council in the United Kingdom or the Hygiene Museum in Dresden, which supports a national committee coordinating health educational activities and maintains shops where health educational material is produced (*21*).

Various screening activities, involving either apparently healthy subjects in the general population, high risk groups, or just patients seeking care, have been in operation for a long time for purposes of case-finding, epidemiological investigation, or both. The fact that health centres, with their staffing, equipment, and record facilities, are particularly suited to these activities has constituted one more argument for the establishment of health centres in Europe (*5*). Screening, of course, has been undergoing a very critical reappraisal in recent years; from a panacea of modern medical care about a decade ago it has become almost a dirty word. Criticism, however, may well have served to reduce the erstwhile hyperbolic expectations to rational proportions. A recent Canadian report (*22*) may point the way by selecting conditions and patient groups where sickness is either preventable or treatable.

Health education, screening and follow-up are the main components of outreach in primary care. Health education, covering such a wide and varied range of activities, can itself involve many other sectors of the community besides the health services, such as schools, industrial establishments or other places of employment, and the mass media. Within the confines of a health centre some limited effects on reducing cost, if not improving health, have been reported such as by reducing patients' insistence on having medicines prescribed (*23*). In a health centre in the United States, the cost of care per patient was cut by 23% over a two-year period by fully informing the patient of his state of health, providing him with plans for treatment and management, and giving him responsibility for physiological monitoring (*24*). Such evaluative studies in the United States are summarized in the statement "that good patient education can result in savings in terms of fewer broken appointments, reduced hospitalization, reduced medication, and other calls on the health care system" (*25*). Part of the new trend is the

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teaching of self-care—after having for many years urged people to see their doctor for the slightest symptoms and to have frequent routine examinations.

These then are instances of the primary medical service going outside its four walls and sometimes involving other community resources in contributing to the health of the population. But while it goes some of the way, it still falls short of the Alma-Ata concept of coordinating primary care with all other relevant sectors of the community.

Discussion and conclusions

It is the main purpose of this chapter to discuss the variety of services provided by organized primary care in many of the countries of the WHO European Region. This, it is hoped, will provide those concerned with the planning and operation of these services in a particular setting with alternatives, which they may wish either to adopt or to reject in the light of their own experience, or which they may consider as deserving further study.

An attempt to evaluate critically the services provided under the various arrangements described would exceed the scope of this book, not only because of the large number of service packages in existence, but also because it would require studying individual arrangements in far greater depth, and in the context of the larger systems of which they are part, so that important aspects of primary care such as accessibility, quality and comprehensiveness could be fully understood. The socioeconomic–political environment in which primary care services function will have to be taken into account in order to identify incentives or obstacles to improvement. Nevertheless, at least some general conclusions can be drawn regarding the adequacy of the services provided. Accessibility, for instance, is determined by several factors: geographical (distance, transport), financial (direct as well as opportunity cost to the patient), or attitudinal (health and sickness behaviour, knowledge of and attitudes towards the services). Even short of a quantitative data base, it can be assumed that geographical accessibility is improved by regionalization and an equitable distribution of health resources. Removal or reduction of financial barriers will, of course, increase financial accessibility, and community relations, health education and other forms of outreach will increase acceptability.

Quality can at best be inferred from this report, or from similar descriptive studies, at the level of structure: the formal qualifications of the staff, the available equipment, and the existence of supportive diagnostic and therapeutic services. Quality criteria relating to process or outcome require studies in much greater depth.

The comprehensiveness of the various forms of health care organization can be assessed only in the context of other sources of care available to the community, either at the community level or at other levels of the health care system. However, the concept of primary care

that has evolved in recent years, and which led to the agreements reached at Alma-Ata, is contained in the documents emanating from that Conference. They reflect broad international agreement and can therefore be taken as the desiderata for primary care services in the years to come. They thus provide a standard against which to judge the present state and future progress of a specific primary care organization. But it must be borne in mind that those looking to Alma-Ata for a precise definition of primary care and its content will be disappointed. Like the WHO formulation of what constitutes health, it presents a philosophy or principles rather than an operational definition. Also, like the WHO concept of health, the Alma-Ata Declaration makes it clear that, just as health has a component of social wellbeing, primary care must raise its sights beyond the confines of the traditional medical services. Further to be taken into account in evaluating a particular health care system or its primary care component are possible gaps between legislation or policy statements and their implementation. Some systems, such as the British National Health Service, may be designed to provide truly comprehensive coverage of medical care needs, yet effective rationing of resources may render some of the benefits illusory or obtainable only after long delays.

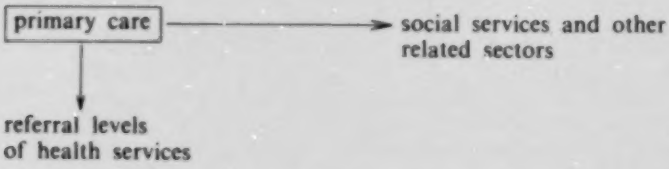
In Article VII of the Declaration of Alma-Ata (*1*) the content of primary care is described as addressing "the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly". More specifically, primary care "includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". More operational definitions have been used at various times for various purposes in order to define primary care, the primary care centre, primary medicine, the primary physician, and health centres generally (*26*) but these definitions vary according to the orientation of particular projects.

Primary care, then, emerges from the Declaration as a subsystem requiring close integration (*a*) horizontally, with "all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors", and (*b*) vertically, in that it "should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need".

Some of the related sectors may seem far fetched. But if food and proper nutrition are important, as they obviously are, this relates directly to agriculture and animal husbandry as well as to the food industry, while industry is also important not only as the producer of

essential goods but also as providing a working environment important for the health of all those employed in it. There is much emphasis in countries of the European Region on intervention strategies for the prevention of chronic and degenerative diseases, but efforts made by health authorities to motivate people to adopt healthy lifestyles are often thwarted by the vested interests of industry and agriculture. Real progress can come about only by close cooperation among these various sectors, as appears to be exemplified, although on a limited scale, in the North Karelia project in Finland.

In the joint report to the Alma-Ata Conference by the Director-General of WHO and the Executive Director of UNICEF, primary health care is described as "the hub of the health system" around which "are arranged the other levels of the system whose actions converge on primary health care in order to support it and to permit it to provide essential health care on a continuing basis". Prominent among related community services are the social services, and the two-way integration process can be depicted thus:



It follows that an assessment of a primary health care system must take into account the relationships of primary care, both horizontally and vertically. Clearly, it was not intended at Alma-Ata to deny the need for the referral levels in the health system, but these levels must be designed to effectively complement the primary care at the hub of the system.

It should be noted that the Declaration places health education and prevention at the top of the list of services to be provided, with treatment and provision of drugs at the bottom—an indication of priorities to which many of the countries in the Region have in the past paid only lip-service. Prevention of chronic, degenerative diseases, which are prominent in many European countries and gaining in importance in others, is the target of various intervention strategies, while the infectious diseases have in general been successfully controlled. It should be remembered here that the control of the infectious diseases owes its success not to the medical treatment of those affected, important as this is, but to prevention. Similarly, it may be expected that the control of the chronic diseases can also be brought about by prevention rather than by treatment of the sick alone.

Some of the content of the Declaration of Alma-Ata obviously relates primarily to non-industrialized and largely rural countries of the world. But lest there be any misconception that those principles do not apply in Europe, or do so to a lesser extent, the Regional Director has commented on primary health care in Europe in the wake of the Alma-

Ata Conference (*2*). Regarding the scope and content to be assumed by primary care in the Region, he states:

> Only a relatively small fraction of the health problems of the European Region, in both the developing and the industrialized countries, can be solved by curative medicine. The resulting, and inevitable, emphasis placed on PHC—prevention, promotion, health education, rehabilitation, and social measures—requires a more systematic approach to individual behaviour patterns, social conditions, and health in relation to development. Many countries in Europe have already reached the target of full primary medical care coverage for the population. The task now is to convert this *medical* care into the broader, more comprehensive (and ecologically satisfying) *health* care.

Here again, the emphasis is on broadening the traditional primary care concept, implying prevention, outreach and community involvement with the resulting implications for the kind of services to be provided and the types of personnel needed.

In commenting on ways of reaching the goal set in Alma-Ata of "the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life", the Executive Board of WHO formulated strategies for achieving that goal (*27*). Reference is made to the minimum of services to be provided by primary care, and measures needed to provide these services. These include community support, appropriate technology and manpower, the necessary referral process, research, reorientation of the existing system, and the support of other sectors. Different countries will, of course, emphasize different aspects according to their particular needs. It follows that the functions of health centres, clinics or similar forms of primary care organization will evolve in terms of the provision of medical care (preventive, therapeutic, and rehabilitative), the training of appropriate personnel (especially with regard to teamwork) and the role of the primary care organization in general community development.

This last point is of particular interest when viewed in the context of the changing role of medical care in community services. Originally it was part of, and subordinate to, the general community concern of providing for the poor. With the development of medical science it evolved into a field of its own where scientific–technical knowledge would be applied, largely separate from what happened in the surrounding community. More recently we have begun to realize that, as human nature cannot be neatly split between its physical and social functions, neither should the care for humans be divided into independent compartments. Hence, the Declaration of Alma-Ata and the WHO strategies directed towards the goal of health for all envisage primary care again being closely integrated with other community services and social development. It is one of the aims of this book to indicate the different extents to which primary health care organization in the countries of Europe approaches the newly formulated concepts of health care.

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5

Records and information

The services provided by primary care organizations as described in Chapter 4 are reflected in the records kept. There are also other records of a purely administrative nature, not reflecting services provided to patients or the community, which lie outside the immediate concern of this book. These are, for instance, records relating to building maintenance and housekeeping services, lighting, heating, and payrolls or other personnel matters. Although not further discussed here, these administrative records are nevertheless important for evaluation purposes whenever services or their outcomes are to be related to costs. Furthermore, records can and should be so designed that, wherever possible, the same record can be used for several purposes, including both service and administrative functions.

The following broad categories of use may then be distinguished:

—patient care
—administration
—financial operations
—evaluation and planning
—epidemiology
—other research and teaching
—legal purposes

The primary function must always remain the care of the patient, and this must be given priority in the design of the record system and in the allocation of resources. The report of the Alma-Ata Conference in 1978 (*1*) warned against an over-ambitious record design: "the collection of information has to be kept to the minimum required" and "it is important to identify only that relevant information which is going to be used in the community or the referral system". The obvious message behind this statement is that resources devoted to records should not detract from the service function of the primary care facility, and that in any case the content of the record must be relevant to its potential use. The report does not belittle the usefulness of a more elaborate record system but, it continues, "quantitative precision can be built up over

time" and "every level of the health system has its own information requirements concerning primary health care". It is further stated that whatever record system is appropriate under the circumstances "should be an integral part of primary health care activities and their supporting services" and that information gathering and analysis should not be carried out separately from the service activities.

It stands to reason that an organized primary care facility such as a health centre is better suited, in terms of available personnel and equipment, to maintain a record system suited to the various demands for information than a solo practitioner who may have at best the assistance of a receptionist. This is not to say, however, that good records are not kept and valuable research has not been performed by sufficiently interested and motivated single-handed practitioners. Just as the teaching facilities provided by health centres perform services for society at large, so epidemiological and health services research contributes to health promotion at large, reaching beyond the population covered by a health centre.

A very important consideration in the design of a record system is the kind of data processing facilities available. Here again lies the advantage not only of an organized primary care facility, but also its connection with the broader health care system. This applies both to the routine use of records as well as to their providing a source for ad hoc studies. Good records and adequate data processing and analysis face more complex demands today than they did when communicable diseases constituted the main health problem, and when simple counts of cases served most demands for knowledge and intelligence. Today's problems of chronic diseases and handicaps, both physical and mental, are far more complex in their etiology, elusive in their onset, and variable in their course and the services they require. Together with accidents, these health problems are becoming increasingly important in all countries of the European Region, and are now the most important in many of them. This is paralleled by the corresponding complexity of services and rising costs, which demand greater accountability for what is being done in primary care, as in the remainder of the health services.

When patient care becomes more complex, so do the demands on the record system. This goes for records pertaining to the care of individual patients, and possibly also their families, as well as their extended use in a variety of directions:

— clinical research, studying the epidemiology and etiology of health and disease
— administrative and accounting purposes
— studying the health services, including planning, evaluation, effectiveness and efficiency
— understanding social phenomena such as health and illness behaviour, attitudes, expectations, and satisfaction.

To meet these emerging needs for information we need more highly

developed theory in these areas, more highly developed statistical methods, and the necessary electronic data processing equipment.

The quality of the resulting information, however, depends on the quality of the original recording. This leads back to the view, expressed at Alma-Ata, that records should not contain data which either cannot be adequately ascertained routinely (e.g. the routine recording of occupation or other social data) or which are unlikely to be useful either in the care of the patient, in the administration of a particular primary care facility or of the health care system as a whole, or in the extended study of health and health services.

It is clear that good primary care and the newly emerging needs for research, as well as the need to assure the public of the efficient and effective provision of primary care, render it essential to build into every primary care programme the record system best suited not only to day-to-day patient care and management but also to evaluation and future planning. The better organized the primary care, the better are the chances that these objectives will be met. The record and information systems now existing in the countries of the Region vary widely in this respect.

In many parts of the European Region, with its great variety of health service systems, records and their use vary from one primary care facility to another, and each perhaps has certain advantages or disadvantages. It would be impossible to provide a complete or even a representative picture covering the entire Region. I shall attempt here to describe some of the records obtained from selected health centres or similar facilities, and to report descriptions provided by some of the national health agencies that contributed to the study. The emphasis is not so much on the detailed content or the form of records (although the problem-oriented record, for instance, is mentioned here and there) as on their objectives and the use made of records outside their immediate function of service to the patient. Hence, while no claim can be made for the completeness of the following descriptions, they may indicate various alternative approaches and principles of which certain desirable features might be applicable elsewhere.

Records and their immediate use in patient care

In national health service systems one usually finds that the records used are standard for the entire system. A WHO Travelling Seminar studying the organization of medical care in the USSR (*2*) described the record system in the polyclinics: "record keeping in the polyclinics follows a standard pattern of conventional case-history notes and clinical records of follow-up visits. . . . Reports of investigations, hospital in-patient summaries, reports from fellow-specialists and others are kept in the one record folder. Filing is by street and alphabetical order, since the 'ucastok' is a geographical entity".

The Bulgarian Ministry of Public Health emphasizes that unified record forms are used by all units rendering primary care, and that the

"personal health record" for each individual also records work disability, incidence of diseases, dispensary check-ups and other relevant events, as well as the registration of death.

The principles underlying the record system in primary care in Czechoslovakia are described as follows:

> At polyclinics persons are admitted for examination or treatment through a central card-index office, which is situated in the polyclinic and there all health records of persons from the respective catchment area are stored. The person visiting the clinic informs the office, usually the nurse, of the purpose of his visit. The nurse locates his health record and sends the patient with his record to the appropriate physician. General practitioners located in polyclinics, as is the case in towns, share the record with the specialists in that clinic. In rural health centres, on the other hand, the general practitioner keeps the record file in his own office. In the polyclinics, therefore, the uniform health record is available to the entire medical staff. Where the office of the primary physician is located outside the polyclinic, specialists of that clinic or of the hospital send them their medical findings and reports in writing. Filing of the unified health record within the polyclinic is according to health districts and within the districts alphabetically. In addition to that record each physician maintains his own list of patients who must be followed up. This includes certain categories of healthy persons such as infants and children with risk factors, workers exposed to known hazards, food handlers and contacts of persons with an infectious disease. Then these physicians have their own register to provide special care to patients with certain chronic conditions such as diabetes, hypertension, and others. A separate register is kept to monitor persons temporarily incapable to work because of illness.

The German Democratic Republic has recently introduced a new and uniform system of standardized records which is considered adaptable to all conditions prevailing in the country.

In Hungary each primary physician keeps his own problem-oriented record and follow-up schedules for the monitoring of patients with chronic conditions. The following types of record are kept: patient card; time schedule for chronic, long-term cases and high-risk groups; files on infectious diseases and carriers; and a sickness benefit diary. In addition there are administrative records for accounting purposes, inventories, etc.

In Poland, special mention should be made of cards prepared for pregnant women, on which are recorded all relevant data up to and including delivery. The cards are then returned to the patient's regular clinic.

Dispensaries in Romania also keep a register of chronic patients under specialist surveillance, as well as of other categories of patients requiring follow-up. The area hospital keeps account of the cost of personnel and materials incurred at the dispensaries.

The above are observations from socialist countries in the Region whose health services display basic similarities in structure. If the various health administrations in these countries emphasize different aspects of their record systems it is not so much to do with differences

in content or recording practices, but rather what a particular administration considers important. Similar considerations underlie the comments from other countries in the Region that have national health service systems but whose structures are more heterogeneous than those of the socialist countries whose systems owe much to the USSR prototype.

In Finland the Public Health Law of 1972, which laid the foundation for the systematic development of health centres in that country, deals in paragraph 18 with the records to be kept by health centres:

> Notes shall be kept in the records of the health centre concerning the state of health of any person who consults a doctor or other person at the health centre, or to whom a member of the staff makes a visit, or who is admitted to a hospital bed at the health centre. Upon request, the health centre shall deliver to any other institution of medical care the information contained in the records of the health centre concerning a patient who receives care at such institution, or shall deliver a copy of such records, or shall lend it such records. Should a person have removed to another commune, the records concerning that person shall be transferred to the appropriate health centre upon request thereby.
>
> Any records which contain such information as is referred to above in the subsection 2 and which are left behind in the district of the health centre by a person who has exercised the profession of physician or dentist in that district, or which belong to a private institution of medical care or medical research that is terminating its activities there, shall be received into the archives of the health centre, to be administered there as an independent section.

These are useful instructions for the maintenance and disposal of records, ensuring in particular that records follow a patient who is referred elsewhere or who moves to another district. The development of a continuous record for every client of a health centre has been under consideration in Finland. Some centres already keep such records for everyone in their target population. These records are built up from child care and school health records. Exchange of records between primary care and hospital or specialist is not always perfect where the referral is made by somebody other than a health centre physician. In one of the private group practices in Helsinki each specialist maintains his own patient records, while the general practitioners have a common register.

Special disease-oriented centres or dispensaries in Finland, as elsewhere, adapt their record systems to their particular requirements. Thus, in a mental health centre, for instance, one would find a card index as well as individual records. The latter are being expanded to contain more social data concerning the patient, such as information on housing conditions, employment, and other relevant aspects of the patient's environment.

The Helsinki City Tuberculosis Dispensary stores all miniature X-ray films as well as a card containing the results of every film. The polyclinic

of the dispensary prepares a report on every patient, complete with laboratory and X-ray results, X-ray films and consultation reports. A number of special registers are kept: a drug registry to record the drugs obtained by the patient; the findings of an "observation group" concerned with patients with an unclear diagnosis; a register for tuberculosis patients requiring treatment; and a follow-up register for patients treated and discharged as recovered. The dispensary also has access to the death register, the national tuberculosis register maintained by the National Board of Health, prison registers, the register of the Cancer Foundation, and registers of drug abusers and vagrants.

Patient records in the health centres in Iceland are pooled and are accessible to all members of the team. The records are in general based on individual patients but in some places problem-oriented records are used. Special filing systems are used for follow-up in immunization and screening programmes aimed at specific risk or disease groups, such as those with hypertension, diabetes or cervical cancer. Where health centres are linked to hospital outpatient clinics, the record systems are coordinated so that only one record is created for each patient.

In the British National Health Service most group practice and health centre records are kept by the physicians on record cards standardized for the National Health Service, but more elaborate folders are used in some places. General implementation of the use of a larger folder, whose layout had been agreed on, had to be deferred because of financial constraints. As a rule, physicians in groups and health centres make the records available to all members of the team and nurses generally keep separate records. Very few centres have so far developed an integrated record system, but several are carrying out research on the computerization of patient records.

Within the United Kingdom, Scotland has been most intent on establishing health centres and observing their performance. The Scottish Home and Health Department describes in some detail the record folders being introduced in the health centres and their management. There is a folder for standard-size inserts. Among the items shown on the folder are the patient's name, sex, date of birth and marital status, and the name of the general practitioner with whom the patient is registered. Included in the folder are the following separate sheets and reports: the clinical record sheet; a summary sheet (which could also serve as the problem list where a problem-oriented record is to be used); a record of immunizations and screening investigations; a maternity record; a paediatric development chart; a mount sheet for X-ray, ECG and clinical pathology reports; and a sheet for the nurse's and health visitor's records. Recommendations for alternative methods of filing vary according to the size of the centre. Alphabetical files are considered adequate for smaller centres; geographical filing by street, block and street number has the advantage of facilitating the assemblage of family records but requires a master index; whereas numerical filing, also requiring a master index, appears better suited to larger centres and may be arranged sequentially or by terminal digit. Among methods of

record storage the Department recommends open-shelf lateral filing. Rotating drums (carousels) are found to be space saving but subject to mechanical troubles, while pull-out drawers may require frequent shifting of records because of inflexible space. Use of colour codes and tracing cards is suggested and reference is made to the advantages of the problem-oriented record. The whole record system is geared to use by multidisciplinary teams.

The experience of one of the Scottish health centres with a computer-assisted record system has been described (*3*). The content of consultations by general practitioners is recorded on portable dictating machines, typed by the secretaries into the patient's notes, and subsequently coded and maintained in a computer file. This file is also used to call in children for immunizations and routine checks, as well as for compiling appointment lists and notifying patients. The system can also be extended to patient contacts with other members of the team, such as nurses and specialists. The cost of this record system is borne by the health authority in whose area the centre is located.

To take an example from the less industrialized and less affluent south-east corner of the European Region, Turkey also has a nationally administered system of health centres, although it covers mainly the otherwise medically deprived areas. It is remarkable that at the basis of the design of the record systems for these health centres or *ocaks* lies the recognition that the health personnel must be thoroughly familiar with the area they are to serve. It is therefore necessary, first of all, to draw the boundary lines of the area, to identify the dwellings and public places to be mapped for every village, and to determine the population, road conditions, distance between the village and the centre, and travel time by foot and various means of transport available to the population. From such a census a list of family members is compiled, which serves both as a population count and also as a basis for the preparation of individual health records. Special records are prepared for pregnant women and for children up to 6 years of age, and for their follow-up and examination. Individual records contain the identification of the patient, medical history, vaccination schedule, illness record, tests and treatments. The records are filed by family name and residence. On first contact the pregnant woman or the child receives a card for appointments and a record is established at the centre. Deviations from the normal are noted and on these individuals checks are carried out more frequently.

The examples described on the foregoing pages serve to indicate the broad spectrum not only of record systems but also of the considerations behind record design and use. The variation increases, of course, as one moves to the pluralistic systems in the Region, where there is no central policy regarding patient care records although there may be prescribed forms to be completed for accounting or other administrative purposes. The ministries concerned, therefore, have no comments in this regard or at best confine themselves to very general statements.

As in the other countries with pluralistic health care systems, with most physicians working in the private sector, the keeping of patient records in France is the responsibility of the attending physician. Great importance is attached to the observance of strict confidentiality by all personnel. While it cannot be said to be a normal procedure, the problem-oriented record is used here and there and some clinics group their records by families. On the whole, however, the information system is geared mainly to administrative and financial requirements. Some centres, such as those of the *mutuelles* in Paris, maintain a central filing system with combined records from all specialties represented at the centre. An elaborate longitudinal record system for the monitoring of children's health has been instituted at the Centre de Bilans de Santé de l'Enfant of the Caisse primaire centrale d'Assurance maladie de la Région parisienne. There the results of extensive periodic examinations of children at 10 months, 2 years and 4 years of age are recorded. The results are given to the attending physician or clinic, and parents receive a summary for inclusion in their record of the child. There appears to be ready exchange of information between physicians and hospitals as well as between physicians in private practice and public clinics or centres.

The Ministry of Public Health and Family Affairs in Belgium also mentions that in existing health centres the records are filed centrally with access for all medical personnel, although the non-medical members of the team are rarely in a position to use the medical information recorded.

In the Republic of Ireland, health centres use record forms prescribed for application in maternity and infant care schemes as well as in developmental paediatric examinations of pre-school children. Otherwise there are no general rules concerning records to be kept by health centre personnel. However, public health nurses on district duties are required to keep registers of elderly persons and of the mentally and physically handicapped in their district.

Extended use of patient records

"Extended use" is understood here to mean the use of patient records or abstracts thereof for purposes other than the care of the individual patient. The main such uses are those for the registration of vital events, which are mandatory in all countries, and for epidemiological or other research purposes such as the monitoring, evaluation and planning of services. In addition, but often related to some extent to the foregoing, are reports of an administrative and financial nature. These are, in general, the objectives of a health information system.

The use of records is much less common in primary care than at the hospital level, where a number of countries do produce routine statistics of morbidity and hospital activities. Exceptions are the health services in the USSR, and those in other countries that follow the same pattern, where a system of "sanepid" stations permeates all levels of the health services. A WHO Travelling Seminar (*2*) reported that in polyclinics "a

record of the diagnosis and disposal at each attendance is made on a small slip of paper and is sent to the statistical section of the local sanitary and epidemiological station, where all attendances are recorded for operational purposes". Similarly, the Seminar found that in the operation of the dispensaries in the USSR "it is possible to assess the working of the system by analysing records to find the numbers of persons under care, the frequency of follow-up and how fully recommendations have been implemented".

In Czechoslovakia information about the actual activities of first contact physicians is obtained from the basic daily record in which, for statistical purposes, data about all patients examined by the physician on a particular day are entered. Mention is made of their age, social status, whether they work or live in that community, whether it is the first or a repeat visit, whether it is a preventive examination, and whether it is a home visit. The patient's diagnosis is indicated and information is entered about referral to hospital or a consultant or to a specialist department of the polyclinic. Mention is also made of whether the patient is fit for work. A series of indices for factory physicians, pediatricians, gynecologists and stomatologists is adjusted to the characteristic features of these specialties. The records also contain information about the number of hours worked by the physician and the nurse. These items are used to build up the information system. Based on these data, ad hoc epidemiological studies of morbidity and its causes are carried out, mostly at the national level although smaller surveys are also done at the regional and local levels. In all these projects considerable use is made of computers.

In Bulgaria, likewise, data derived from the personal health records are used to control and evaluate the services, as well as for statistical and administrative purposes and for registration of deaths.

Primary care institutions in German Democratic Republic produce a number of reports, i.e. on outpatient medical and stomatological establishments, on dispensary care (maternity and child welfare counselling, youth health protection, etc.) and on finances and manpower. The data derived therefrom will form the basis for future guidance and planning. Specifically they will provide an insight into the territorial distribution and profiles of the establishments, the volume and pattern of services rendered, the quality of medical and social care, the use of manpower resources, and cost–benefit relationships. All this is contingent, of course, on the quality of the original data. The availability of uniform and routinely collected primary data will also make it possible to study the course of diseases. The reporting of births and deaths for registration purposes is universal throughout the Region. In Hungary, the primary care physician in attendance reports these events to the local council or its health organ and the physician, in turn, is given information concerning the population living in his district and on any such events not attended by him.

Romania, too, places great emphasis on the importance of the information derived from primary care records in order to appraise the

health of the population. Dispensaries report periodically on consultations and treatment for adults and children, consultations and treatment provided by stomatologists, immunizations, diagnosed cases of infectious disease, services for mothers and newborn babies, home visits to children and chronic patients, disinfection against communicable diseases, and health education activities. They also report on temporary incapacity for work and prophylactic examinations in certain categories of personnel, and on occupational diseases. School dispensaries also report specifically on diseases peculiar to particular age groups. The resulting information is used in decision-making and in implementing technical and organizational measures for the health promotion of the population served.

Finland has introduced specific evaluation forms to be completed by the health centres established under the Public Health Law of 1972.

Iceland has been developing several aspects of its record and information system based on primary care data. Health centres carry out internal quality control through medical audit and peer review; surveillance is also applied by local authorities, and the Chief Medical Officer of Health reviews and publishes annually mandatory reports received. So far, traditional mortality and morbidity statistics have been used as outcome measures. Increasing attention has been paid to effectiveness and efficiency in primary care. The establishment of a computerized national health data bank, with the assistance of the United Nations Development Programme, is being considered. In general research within health centres, so far only scattered, is being encouraged.

For its health centres in the nationalized sector, Turkey has a system of 23 report forms—weekly, monthly and annual—to provide the data necessary for monitoring the service. These forms provide data on population, pregnancies, children's immunizations, clinical services, morbidity, environmental health services, births, deaths, laboratory services, health education activities and emergency services. For each member of the health personnel there are monthly forms for reporting on activities.

The Republic of Ireland requires reports to its community care offices on births and discharges from hospital. This is so that arrangements may be made for home visits to discharged patients and also for care of the newborn, immunizations and periodic examinations of children.

Selected issues

Among the aspects mentioned or alluded to above is the question of confidentiality. This relates to access to one another's records among the several categories of personnel forming the primary care team, e.g. physician, nurse, social worker. It also, and perhaps more importantly, bears on the relationship between the providers of primary care and other agencies or individuals concerned with some other matter

regarding the patient. In some countries statutory provisions—or at least their interpretation—prevent the free exchange of records between health personnel and the social worker. This obstacle is sometimes overcome by discussion of the case among team members from their particular knowledge of the patient's circumstances. In practice, more often than not, the patient will have confidence in the professionals attending his case and will explicitly or implicitly accept that they are all fully informed about both the medical and the social aspects of the case. There may be situations, however, where the question arises as to whether a medical social worker's record belongs to the health team or to the social service department and whether, for instance, the director of the social service department can demand access to the case record of a patient. Some doctors in England have been concerned that the content of their records may reach even wider circles, beyond the health and personal social services (*4*). Their case conferences, they contend, may sometimes include housing officials, representatives of gas or electricity boards or even the police; should they all be entitled to the full minutes of the conference where medical aspects of the case were discussed?

These are questions arising from the multidisciplinary team approach in primary care. The broader problems of confidentiality, however, are shared by primary care not only with other sectors of the health services but with all community services, public and private, that compile personal records. An additional dimension is added where records from a variety of other sources can be linked, for example school, employment, police and credit rating records.

Another feature of the primary care record system that is receiving attention from several health administrations and primary care institutions is the use of the problem-oriented medical record. It has been found useful in a variety of settings. Its use in connexion with a "feature card system" (*5*, *6*) has been described as a simple and inexpensive method of data storage and retrieval to facilitate (*a*) interaction among the various providers of services, (*b*) monitoring of special groups of patients and (*c*) research. The system is computer compatible (*7*). That the problem-oriented record lends itself particularly to teamwork has also been the experience in a practice in the United States, where it has been found that it makes it possible for a number of problem-solvers to work together more efficiently and with greater impact (*8*).

Family-oriented primary care, to the extent that it is practised in the European Region, is but little reflected in the existence of medical family records. A WHO Study Group (*9*), considering the question of indices of family health in 1975, recommended calling on countries "to supply information on operating data bank systems, and in particular on the assessment and evaluation of existing records and registers and their actual and/or possible use for the identification of families". Specifically, the Group recommended that "WHO should encourage the recording of family data on individuals at the time of vital events and when

individuals enter the medical care system". Basic to all this is the notion of the family as a health unit to be further developed, and the Group further recommended that WHO should "consider providing assistance to Member States in developing, improving, and appraising their national data-base on family health". Sociologists for their part are looking for greater application and integration of family theory in health care research (*10*) and they see a need for a more extensive, nationwide collection of morbidity and family data, involving a variety of sources guided by interdisciplinary effort, along the lines suggested by the Study Group. Seen as prerequisites for the family-oriented approach are the development of a standard set of minimum health data, a more extensive data base than generally available drawing on parents and children, an index or indices to measure the health of families, and the recording of the involvement of family members in health care.

It must be noted, however, that the paucity of family records in primary care institutions does not necessarily indicate a corresponding disregard for family considerations in primary health care. In some places it is the nurse or social worker who maintains family files, and primary care physicians frequently practise family care based on their knowledge of family members. The gradual introduction of the term "family physician", replacing the "general practitioner", is some indication of a reorientation taking place. It is part of the holistic approach to health care to see not only the patient but also to consider his problems in the context of his environment, including his family. The family dimension in the health of the individual is also part of the concept of the quality of life as an objective of comprehensive primary care (*11*).

Conclusions

In this project the record system was only one of the various aspects of primary care organization observed and, therefore, was not in itself the subject of systematic study. While the findings draw attention to certain features and issues, much more needs to be done so that those concerned with records and their processing and application can be given an adequate picture of alternative approaches used in the countries of the European Region, of the problems encountered and solutions attempted.

The development and perfection of records in the health field generally reveal an historical pattern reflecting successively emerging priorities. First came the birth and death records, the primary consideration here being completeness so that the records could serve the legal and demographic objectives of the registration of vital events. Since the events of birth and death also marked the stages in life where major health problems occurred or came to light, these records became vehicles for health-related information, such as the recording of risk factors during pregnancy and birth and the medical certification of the

cause or causes of death. The next serious manifestation of ill health is hospitalization. This consideration and the complexity of hospital services led to the gradual perfection of hospital records and the resulting statistics.

Primary care lagged behind for a variety of reasons. For one, primary care lacked the logistic support that had developed for vital registration, and which was more readily available in the hospital setting. Much of what happened in primary care did not appear to have the same degree of relevance as the usually more severe or serious health problems leading to hospitalization or death. Then, the general practitioner was (and often still remains) an independent professional, not subject to rules and regulations as those prevailing in the hospital (and even in the hospital, standards are often less enforceable in private than in public hospitals). Furthermore, the sheer number of general practitioners means that patient contacts in primary care are about fifty times more frequent than admissions to hospital.

As primary care assumes greater importance, however, so does the need for adequate records. The establishment and maintenance of good primary care records is facilitated by the logistic resources available in health centres and similar forms of primary care organization. Computerization, especially the use of mini-computers, permits the efficient retrieval of information as well as processing of large numbers of records. The primary care record, furthermore, assumes greater importance as the fragmentation of care into more and more specialized services leads to the need for a complete record to be kept at the primary care level. The increasing importance attached to prevention, outreach and follow-up demands the records and registers necessary to plan and execute these activities.

As the demands on primary care increase and change, the record systems must keep pace. New technology offers fresh opportunities for record keeping, filing, data retrieval and data processing, but the application of new technology and equipment must be adapted to existing needs and available resources. All these factors combine to add importance to the primary care record and its uses, but at the same time they add to the complexity of the task of designing a system of records and a resulting information system suitable in a particular setting. If primary care is to fulfil its future role, WHO could greatly contribute by arranging for further and intensive study of this subject in order to provide advice or guidance to Member States. One recalls the findings of a WHO Expert Committee (*12*): "The records in use all over the world by general practitioners are of endless variety. The Committee considers it desirable that a study be made of the various types so that a prototype incorporating the best points of each can be prepared."

At today's stage of development one prototype would be over-simplistic, but such a study could address itself to the various aspects of a record and information system and develop for each alternatives suitable for various situations. Among the broad aspects of study could be:

— record content
— record format and design
— record or data filing
— data retrieval
— data processing
— information system

The resulting records will have to serve both continuing patient care and the needs of various registers of certain categories of patient. The present study has shown that a wide variety of approaches to the subjects listed, and possibly other aspects of a record system, exist or are planned. With the future importance of primary care records for patient care, as well as the extended applications in monitoring, planning and research, it would be very useful to study the experience with alternative methods and to obtain a clear picture of the effectiveness and efficiency of the various complex and costly means of modern record keeping and data processing in the primary care setting. These are largely technical and administrative questions.

The Alma-Ata Conference dealt with principles of record keeping and use for information purposes, and it stipulated certain general desiderata. Reference has already been made to the need for "the right kind of information" and that "the collection of information has to be kept to the minimum required". There are further considerations relating to the information system to be derived from primary care records. Paragraph 110 of the report on the Conference (*1*) states:

> Any information-gathering and analysis required should be an integral part of primary health care activities and their supporting services; they should not be carried out separately. They need to be included in plans from the beginning, and information should be gathered or transmitted only for the two purposes just mentioned, and be restricted to the minimum.

Here again is the admonition to keep records to the realistic level of what is relevant. The two purposes referred to are described in paragraph 109:

> To be of practical use, the reporting of information from one level to another has to be two-way, only that information which is actually required by the other level being transmitted. Usually this information will be of two types: information in response to which immediate action is required, and information on which to base more general inferences, evaluation and subsequent modification of programmes as required.

The latter sentence contains an explanation of what is relevant. As to the transmission of information from one level to another, one gains the impression that, generally speaking, in the European Region the problem often is not so much one of too much information transmitted but perhaps rather too little and frequently with too much delay.

Regarding research based on information from primary care sources, paragraph 111 states:

> Enough is already known about primary health care for it to be put into practice immediately. However, much still needs to be learned about its application under local conditions, and during its operation, control and evaluation problems will arise which require research. These may be related to such questions as the organization of primary health care within communities and of supporting services; the mobilization of community support and participation; the best ways of applying technology available or the development of new technologies as required; the planning for and training of community health workers, their supervision, their remuneration and their career structure; and methods of financing primary health care. Whatever the substance of the research, building it into the programme from the outset makes it a practical way of promoting continuous improvement.

How the principles agreed to at Alma-Ata are to be implemented and "health for all by the year 2000" is to be achieved is further elaborated in a document of the Executive Board of WHO (*13*). Considerable space is devoted in that document to the description of the research and information required for the planning, monitoring and evaluation of health services: "Governments have a responsibility to ensure that the research required is a natural component of the health programme to which it relates, and that health managers are also involved in its conduct as appropriate". Recommendations are made for regional and global information exchange.

In summary, answers to several questions must be found if the system of primary care records is to fulfil its objectives. In all cases, the health centre setting will facilitate finding the appropriate solutions, including those regarding the design, keeping and processing of records. Among the questions to be answered is who the records belong to—the patient, the provider of service (doctor, nurse, social worker, etc.), the health care system, or a combination of these. Questions have been raised regarding the patient's right of access to his records, as well as the right of third parties such as insurance or compensation agencies.

General practitioners frequently still regard their records as their own domain and they are satisfied as long as the information kept supports their own memory and knowledge of a case. The result is often a record which is inadequate for use by anyone else in the continuing care of the patient and, partly because of that inadequacy, there is a reluctance to share the record with others concerned with the patient.

Another question relates to the use to be made of the record, i.e. whether for patient care, various administrative purposes, or research. Most records will share elements of each of these. The nature of the system in which a primary care facility operates will determine the degree to which records are standardized to serve the various purposes.

An important question, particularly in times of economic constraint, is what proportion of available health resources should be devoted to records and information processing. The answer here will depend on the foregoing question regarding the use or uses of records, as well as the optimal balance between special interests and the overall needs of the system.

A study of existing record and information systems would provide a firm basis for the required research and at the same time contribute to the improvement of patient care at the primary level. Rapid technological advances in the recording, processing and analysis of data will require periodic reviews of the state of the art.

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6

Management and decision-making

This chapter focuses mainly on the internal mechanisms for managerial monitoring and decision-making in various forms of primary care organization. However, it is not always possible to separate clearly external policy for the primary care facility from internal planning and management. The clinical management of patients has been discussed in Chapter 3 in the context of the team and the distribution of responsibility within it. Of course, the managerial decision-making process also depends largely on the degree of autonomy of a particular primary care facility, and the auspices under which it operates. Group practices and health centres in the private sector, prevalent in the pluralistic health care systems of the Region and also in the British National Health Service, exercise a high degree of autonomy, subject as they are only to general licensing provisions. A similarly high degree of autonomy, although of a different character, exists in the Yugoslav primary care institutions, where it is subject to the checks and balances of a central and regional planning system and the "social agreement" within the local community (*1*).

In some systems where primary care is strictly regionalized, there may be a hierarchy of primary care facilities ranging from the local health station to a central polyclinic. Here certain aspects of management follow a correspondingly hierarchical pattern whereby certain managerial functions of the smaller facility are assumed by the more central level; similarly, certain administrative functions for the local primary care facility may be centralized in the district hospital. These may include matters concerning auxiliary and administrative personnel, transport (including ambulance services) or other functions not directly concerned with patient care. These are external factors that influence the scope and content of internal decision-making. There are also certain aspects of internal relationships that bear on the question of who makes what decisions and how in a primary care facility.

The previous discussion of teamwork was in relation to the care of the patient. But the kind of relationship established there and the mutual acceptance among team members of their respective roles (or of a strictly hierarchical structure) are bound to spill over into patterns of

management; established lines of communication and levels of morale have their effect both on style of management and patient care. The style of management in a particular centre—in systems where it is not standardized as a matter of national policy—varies also with the prevailing concept of primary care. Where this is largely left to the individual group of practitioners, it still follows generally the traditional passive pattern of strictly medical care, i.e. waiting for the patient to consider himself in need for care with little or no attention to prevention, outreach or liaison with other community services (*2*).

Planning, monitoring and evaluation as management tools assume different proportions where the principles of the Alma-Ata Declaration are implemented, since these aim at the integration of primary medical care with all other community activities bearing on health. This implies the use of a wide variety of resources, besides the strictly medical ones, and entails understanding and coordinating a complex system where the requirement for one resource may be dependent on the use of others. This in turn implies the development of simulation models for use in managing the available resources (*3*).

The scope of administrative decision-making and procedures outlined for outpatient services in hospital clinics in the United States (*4*) exemplifies basic areas of administration in first-access facilities. Ten such areas are listed: structure (clinic days, hours, joint arrangements); function (patient groups, disease categories, teaching, research); admission and disposition (eligibility, access, referral in and out); fee payment; appointment system; clinic time patterns; staffing; medical procedures and equipment; clinic procedures (appointments, preparation of clinic); and records (patient charts, administrative records).

Monitoring of performance and evaluation constitute integral aspects of management. This means relating resources, or inputs, to the quantity of services provided, or outputs, and applying some outcome measures in order to determine the effectiveness. Where outcomes are difficult to observe or quantify, such proxy measures as structure or process are being used to observe the quality of the services provided. This full extent of evaluative management is as yet little developed, and is largely limited to categorical programmes or costing procedures.

Apart from other administrative levels that may impinge on the autonomy of management of a primary care facility there is, where it exists, the participation of the community or population served. This may range from an advisory to a controlling function, and it may comprise all management functions or certain aspects of policy-making or administration. Community participation is another aspect of primary care organization that received new emphasis in the Declaration of Alma-Ata. Community participation may be provided through the local representatives elected in the general political process. This form of community input exists where primary health care is a function of and is financed by local government, although the health function may be exercised by a special health board. The other form of community participation consists of ad hoc representation of the population

covered, patients, or subscribers for a particular primary care programme. One way or another "measures have to be taken to ensure free and enlightened community participation" if the objective of health for all by the year 2000 is to be achieved (*5*). This is strongly emphasized in the Declaration of Alma-Ata, which states that primary health care "requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate" (*6*). There is a responsibility here for community education to achieve effective participation.

These various aspects of management in the primary care setting are differently developed or emphasized in the many and varied settings in the European Region. The following section provides examples of how the functions of management and its limitations at the primary care level are seen in some of the countries. The description will move from the highly structured socialist to the pluralistic and open systems in the Region.

Management functions

In the highly structured health care systems in the Region, i.e. mainly those in the socialist countries and to a lesser extent in Scandinavia and the United Kingdom, much of the planning for primary care and the consequent management take place within a set of norms or guidelines with different degrees of scope for adjustment to local conditions.

Norms and standards in the USSR, as well as their application in planning and evaluation, have been described in some detail by Popov (*7*). He makes the distinction between scientifically determined norms, which establish needs, and standards, which are empirical "indices relating to the resources required to meet the needs specified by the norms." Research is necessary to keep the norms up to date and national standards may have to be adapted to regional situations. Corresponding standards are in use in other socialist countries and are increasingly developed elsewhere, particularly in the field of hospital planning in terms of bed:population ratios under the pressure of cost containment policies. The degree of freedom in decision-making within the individual primary care facility depends on the strength of directives or guidelines emanating from the central authority. This, in turn, is related to the extent of centralization in the financing mechanism.

The difference between the health services in the socialist countries and national health services elsewhere, for instance those in the Scandinavian countries and the United Kingdom or the new systems in Italy and Portugal, is that in the socialist countries health planning is an integral part of total national, economic and social planning, whereas national health services elsewhere function in an environment of large non-nationalized areas of the economy and other services. Also, these

latter systems are in themselves not always fully socialized in the sense that all personnel are public employees and all facilities publicly owned. Institutions for the education and training of personnel in the socialist countries are more likely than elsewhere to come under the ministry of health rather than a separate education authority, thus making for closer coordination between manpower development and the service.

As in other completely socialized systems, where all personnel are public employees and establishments publicly owned, the health services organization in the USSR is hierarchically structured, so that accountability at each level is to the next higher level – in administrative matters to the next higher department and in regard to methods of work and other professional matters to the next higher chief physician. Within each *rayon* (district) the chief physician of the central hospital heads the health services, and he is directly responsible to the Soviet of Working People's Deputies. His functions include the organization of medical services in the *rayon*, their financing, and the provision of supplies and equipment. He also supervises the introduction of modern methods and the allocation, utilization and training of health personnel in the *rayon*. The chief physician of the *rayon* has a senior deputy responsible for the medical services, and for every 20 000 population there is a physician to deal with advisory services, organization and methods.

The horizontal relationships with the community at large and the population served are maintained with the health commissions of the local Soviets of Working People's Deputies. These commissions check on the work of all public health establishments, participate in discussing the budget and plan for the development of the public health system, give assistance in building curative establishments, and encourage the public to help in carrying out large-scale measures to improve the sanitary conditions in centres of population. Special coordinating mechanisms exist between the medical services for industrial workers and the industrial establishment. Effective health protection of the workers, particularly the introduction and maintenance of preventive measures in the industrial environment, require close relationship with management and trade unions as well as with such other organizations as the social insurance councils, commissions for reducing morbidity, and the organizations of the Red Cross and Red Crescent Society. Collective agreements between management and trade unions cover measures to improve working conditions and safety, including implementation of the necessary sanitary and hygienic measures. Relevant demands on management by the health authorities have the force of law (*8*).

In Czechoslovakia the traditional organizational pattern has been that the services provided by the primary care physician are monitored and directed by the director of the hospital in which the polyclinic is located and the chief physicians of specialist departments (primarily of internal medicine but also surgery, gynaecology and obstetrics, and stomatology) as well as the District Hygiene Officer. Consideration is given to the establishment of the post of district physician for first line services, whose responsibility would be the management and supervision

of the activities of general practitioners in the district. This supervision includes inspection of the medical services provided, including assessment of incapacity for work, ensuring up-to-date practices, and upgrading the professional qualifications of health personnel at the primary care level. Furthermore, primary care services are evaluated regularly once or twice a year by the management of the District Institute of National Health and the Department of Health and Social Affairs of the District National Committee, and at least once a year by national health administrative bodies, national committees, industrial concerns and the Revolutionary Trade Union Movement. At the district level, industrial health services are evaluated by the respective directorates of the establishment and by the Revolutionary Trade Union Works Council.

Hungary exemplifies the role of local councils which, within the framework of national policy laid down by the House of Representatives, make the decisions regarding the operation and development of primary care services. In rural areas the general practitioner advises the local council in health matters; in towns the local councils have special health committees. At the national level, the decisions of the House of Representatives are prepared by an expert committee.

The principle of self-management of industrial as well as health institutions in Yugoslavia reflects the high degree of decentralization of management generally in that country. This has been described as "decision making in a system of direct democracy" (*9*). The emphasis on self-management not only confers on the individual institution a substantial degree of autonomy, but it also combines with high levels of self-management for the component parts within the institution. In respect of their management, Yugoslav primary care institutions are unique in the European Region, and therefore may bear special scrutiny.

The organization of each institution is geared towards two broad aspects of its operation: one aimed at functional, the other at social integration. Functional integration means the organization required to achieve the objectives of the institution – to discharge its public obligation of providing services in accordance with the institution's goals. This implies provision of the necessary resources in terms of personnel, facilities and equipment and their fusion into an operational entity. In this respect, the principles of autonomy and self-management mean self-determination. However, setting the objectives of the institution implies a commitment to the population served, which cannot be determined by the institution alone but must have some input from the community. This is provided by a professional collegiate body which, although advisory, significantly influences decision-making within the institution. Social integration, on the other hand, aims at reconciling group interests and resolving intergroup conflicts within the institution.

Two organs have been created to provide, respectively, for functional and social integration—the council and the management

board. The former, concerned with the commitment to the community, includes external members representing civic authorities, social insurance funds, and other allied organizations specified by the Statute governing health institutions. The external members constitute one fifth to one third of the membership of the council; they are not eligible for the chairmanship of the council. The second organ, the management board, consists exclusively of members of staff of the institution, including non-professional staff. It concerns itself with internal management.

The checks and balances, within which autonomous self-management works, are evident in the community representation on the management council, as well as in federal and republic directives and guidelines. This compatibility is formalized in the "social agreements" between health institutions and the other social and political institutions in the community, so that coordinated planning can be achieved (*1*).

Close liaison between the primary care facility and the community it serves is also provided in the Nordic countries. In Finland, for instance, the local health board, appointed and supervised by the elected council, employs the staff of the health centre and is responsible for its planning, operation and development. The system is thus seen to operate under democratic control whereby community involvement and participation play a vital role: "without local initiative progress is slow, but once a local community develops its PHC [primary health care] following the guidelines of national plans, it is supported by the State by allocating personnel and providing financial support (both capital and running costs) within the limits of national resources" (*10*).

Regarding the composition and functions of the local health boards, the Public Health Act, 1972 provides that the local board of health shall be divided into a general department and a supervisory department. The supervisory department shall deal with matters concerning the health care aimed at the environment of the individual, and the general department with other matters devolving upon the local board of health. Certain matters, however, such as preparing the budget and the annual report, delineating terms of reference, personnel, and other common matters are dealt with by the board as a single body. Local planning is carried out by the health centre and the local health board within national guidelines. The local plan is then reviewed by the provincial board before being submitted to the national board, where it is reconciled with the national plan and the national budget. The national guidelines are meant to be broad enough to permit local plans to take into consideration the local population structure, geographical factors, and other local features requiring special attention. The Public Health Act, however, lists certain prerogatives retained by the National Board of Health, i.e. the approval of health centre premises and the number of beds, which may require supplementary training for staff members; the penalty for abuse of or non-compliance with existing provisions on the part of the centre is discontinuance of State finance. The government's general argumentation regarding the provisions of the Public Health Act makes it clear that "the National Board of Health

was to retain the highest direction even in respect to the State's regional administration as well as the control and supervision of the health work run by the communes." Another factor limiting local autonomy may be the need for smaller communities to consolidate their health care functions by forming "communal federations" in order to provide a sufficiently large population base for a health centre.

The Finnish Province of Lapland, perhaps more than any other part of the country, has its particular regional health problems and specific demands on the local health services. In describing these, R.-L. Luukanen (unpublished data, 1977) refers to the advantages of decentralization but also points out the resulting demands on the administrative medical officer, who must be familiar with all medical and non-medical aspects of the service. The medical officer must also be something of a politician to get decisions through the central ministry, whose head is usually a lawyer but may be a minister of religion, psychologist or member of some other profession.

As to monitoring the quality of care provided, criteria are more readily developed for specific services or programmes than for the overall performance of a primary care facility. Standard practices and procedures are easier to design, implement and observe, and some outcomes at least are more immediate here than in the monitoring of general levels of morbidity and mortality. This applies, for example, to maternal and child care and to specific disease-oriented programmes frequently carried out in special dispensary clinics. The Helsinki City Tuberculosis Dispensary, for instance, among its criteria for the monitoring and evaluation of services, lists the response rate of people asked to have X-ray examinations, the regularity of drug use and dispensary visits, the incidence and prevalence of the disease in the general population, and the results of treatment. Regular checks are made of such technical procedures as X-ray examinations, laboratory tests, and drug distribution and consumption.

An interesting combination of community control and self-management exists in health centre management in Iceland. There the health centres are also governed by a local board, the majority of whose members are chosen by the local council while the staff elect from among themselves one third to two fifths of the members. Here, as in Finland and other Nordic countries, the degree of local autonomy matches local responsibility for the financing. The local community is responsible for hiring and the salaries of health centre personnel with the exception of physicians, nurses and midwives, who are appointed by the Minister of Health and Social Security. Thus secretarial and clerical staff, laboratory and X-ray technicians, and administrative and maintenance personnel are the responsibility of the local authority, which also shares the capital costs with the state. The salaries of physicians, nurses and midwives cover the preventive component of their work, while curative services are paid for on a fee-for-service basis by the Social Security Administration, which is a branch of the Ministry of Health and Social Security. When a health centre is linked to a hospital,

the centre is operated as a department of the hospital and is governed by the hospital board, whose members are chosen in the same way as those of other local health boards. The objectives against which the performance of health centres is evaluated are stated in the first paragraph of the Health Services Act of 1st January 1974: "Every citizen shall be able to get the most complete health service which can be given at any one time for the protection of mental, physical and social wellbeing and health."

Health centres in Sweden can still be considered as being in a developmental stage whereby different centres cover, or at least stress, different aspects. The centre in the town of Tierp, for example, brought together several rural practices, coinciding with the administrative merger of seven municipalities (*11*). It combines medical, social and school health services, and from the early preparatory stages has included a systematic programme of research on monitoring and evaluation.

Because of the multi-agency, as well as multidisciplinary, structure of the centre, a coordinating group was formed consisting of the registrar of the centre and the heads of the local social welfare and education departments. The functions of the group include coordination within the centre, between the centre and other community services, and between the municipal and county authorities. The area covered by the health centre is divided into four parts, each with a group responsible for organizing preventive services in its community. The membership of the four groups includes representatives of social welfare and district nursing, district medical officers, home care officers, and a school representative. Personal health care is provided by four joint social–medical teams. The area groups and joint social–medical teams function within the framework of the health centre, whose three main branches of medical care, social welfare, and student care are coordinated by the coordinating group.

Unlike those systems in which primary care physicians and other personnel are employees of the public service and therefore part of the organizational structure of that service, in countries such as Denmark and the United Kingdom general practitioners, dentists, pharmacists and sometimes physiotherapists are independent professionals who enter into contract with the system for their services. They therefore manage their own affairs, within the provisions of the contract, whereas other personnel such as home nurses, public health nurses, midwives and social workers are public employees, sometimes seconded to general practices.

In the United Kingdom, to the extent that true health centres exist, as distinct from group practices, they are established and operated under the auspices of the health authorities. In larger centres an administrator, responsible for the day-to-day running of the centre, may be employed by that authority. There is usually a management committee, which may have subcommittees dealing with various aspects such as general practitioners, finance, research, nursing and nonprofes-

sional staff. The administrator coordinates these committees and subcommittees.

The shift of emphasis from hospital to primary or community care in the United Kingdom, as elsewhere, also brings about wider use of teamwork, involving other types of personnel besides the general practitioner. The availability of more equipment for diagnosis and treatment, together with the corresponding technical staff, all combine to create the kind of organization that group practices or health centres can provide. The existence of such an organization, in turn, facilitates more efficient use not only of personnel and equipment but also of such ancillary components as transport, office equipment, telephone services, record systems and other aspects of maintenance and administration.

In Scotland the responsibility for the planning, commissioning and operation of health centres rests with the health boards, within the framework of the local organization. This leads to the centre, and the services provided by it, being clearly identified with the overall provision of health care in the community. Clinical services remain the primary concern of the general practitioners and, where appropriate, their professional colleagues. General administration and management, however, are the responsibility of the health board, exercised through district or sector management teams. It is for health boards to determine the need to form sectors within districts and appoint sector administrators to them. The Scottish Home and Health Department considers non-medical administrators as essential members of the health centre staff. They are responsible for the management of the non-clinical services and clerical staff, and are employed by the health boards as members of the management team below district level. An appropriate charge for their services is made against the general practitioners in a centre. The Department considers the responsibilities of the health centre administrator to fall into the following reasonably well defined categories:

— arrangement of the duties and training of secretarial, clerical and other non-professional staff
— promotion of an effective system of communication within the building, with outside agencies and with patients
— provision of secretarial support for the health centre committee and its various subcommittees
— implementation of decisions of professional staff
— obtaining of non-technical supplies and equipment
— liaison between the health centre and other executive departments concerned with its proper functioning
— supervision of cleaning, maintenance, decoration, repairs and security of the building.

In summary, these are the day-to-day duties needed to support the requirements of the professional staff. The Department stresses the need

for the administrator to take up the post several months prior to the opening of the centre because much has to be done in preparing for the receipt of equipment, furniture and supplies, in arranging for the transfer or appointment of non-professional staff, and in preparing for the movement of practices and other services into the building.

Regarding the use of a treatment room in health centres in Scotland, the Department lists the following matters to be decided jointly by general practitioners and nursing staff:

- the hours during which the facilities of the treatment room are to be available, taking into consideration the fact that the majority of first referrals will occur during the general practitioner's consulting times
- arrangements for an appointment system for return visits
- whether self-referrals to the treatment room are to be accepted
- the range of procedures to be undertaken by nurses
- conditions for reference back to the general practitioner
- the availability of equipment, drugs and dressings for treatment room use.

The treatment room in a Scottish health centre is a room set aside for the following procedures: cleaning and suturing of minor wounds; dressings; immunizations; therapeutic injections; other therapeutic procedures such as ear syringing and special treatment for varicose ulcers; and certain diagnostic procedures such as venepuncture and cervical cytology.

These are also the kind of procedures that may distinguish the various administrative and organizational forms in which community nurses participate in the primary care team elsewhere in the British National Health Service. General practitioners have remained independent contractors with the National Health Service, and it is up to them how they organize their practice, although national policy favours group and health centre practice. It is also up to them whether they want nurses on their team. If they do, there are two possible arrangements: the practitioner or group may employ a nurse, or a nurse may be seconded ("attached") to the practice by the health authority. That the two arrangements may have different effects on a practice is hinted at by a study carried out in one practice in England (*12*). It was found that 30% of the procedures carried out in the treatment room of the practice were not part of the usual nursing curriculum and therefore, if they were to be carried out by the nurse, required initial supervision and assessment or training or both. This could be given to an employed nurse, with the result that the treatment room made an important contribution to the work of the practice. According to the study it would not have been possible, however "if the staff concerned had been attached nurses requiring area health authority authorization for procedures carried out as opposed to practice nurses for whom procedures were authorized on a personal basis". Incidentally, it was found that the employed nurse enjoyed more professional independence

and hence greater job satisfaction. Among the procedures in question are venepuncture, vitalography, audiometry and ECG. In 1976, 24% of practices in England employed nurses directly, compared with 69% which had attached nurses.

An example of the overall management of one of the health centres in Scotland illustrates the fusion of professional and administrative decision-making in such a centre (*13*):

> The "day to day" management of the health centre team is vested in a House Committee, a Chairman being elected annually. Monthly meetings are held at which all practitioners attend and in addition delegates representing nurses, secretaries, and the Joint Advisory Committee Administrative Staff. Minutes are kept by the Senior Secretary who is responsible for preparing the monthly agenda with the Chairman of the House Committee.

In the Republic of Ireland the Programme Manager for community care under each health board plays a role similar to that of the health boards in Scotland, in that his duties include the supervision and evaluation of the services provided at health centres within his area. He has to take whatever action appears necessary to maintain these services at the optimum level, while the Department of Health retains overall responsibility.

In Turkey the provincial health centres functioning within the national programme come under the Ministry of Health and Social Assistance, and are administered by the Directorate-General for the Nationalization of Medical Care. The aim of evaluation of the services is the prevention of illness and treatment of the sick so as to reach levels of maternal and infant mortality and life expectancy comparable to those in the developed countries. The Ministry is guided by the statistics it receives. The internal management of the health centres lies in the hands of the chief physician.

In the pluralistic systems of the European Region the mechanisms for management and decision-making vary with the multiplicity of auspices under which medical groups or health centres operate. Private groups of physicians make their own arrangements, subject only to general licensing provisions. These are supplemented, for example in France, by minimum standards laid down by insurance carriers for the erection and operation of health centres, specifying such matters as requirements for personnel and provision of insured services. Furthermore, sponsoring agencies will lay down policies to be observed by their centres. Participation of the population served is as yet little developed, with the exception of a few centres that have adopted such a policy. Participation of the staff in decision-making also depends on the type of organization and sponsorship. In centres sponsored by the local municipal council there may be a committee appointed by the mayor to control the affairs of the centre, but this control consists largely of a review of the budget for the centre. Evaluation of the services is as yet little developed.

Similar variation prevails in the Federal Republic of Germany, where

the provision of health services has been described as being guided by three principles: free choice of doctor, free practice by the professions, and health care delivery to the insured population through the self-administration of panel doctors and sickness insurance bodies. The *Sozialstationen* in the Federal Republic of Germany are subject to plans and guidelines developed by the individual *Länder*, which form the basis on which grants to these stations are allocated. Voluntary welfare organizations sponsoring and financing such stations will also provide guidelines for their operation, where applicable in agreement with the local community or communities served by the station. Guidelines provided by Rheinland-Pfalz, for instance, contain quite specific provisions for the operation of the stations (*14*). Coordinated services are to be provided under central management and decentralized administration. This requires common discussion among the professional staff at least once a week. These conferences serve in particular to design the work programme, to exchange experiences and to clarify issues in doubt. There is to be a written record of these conferences. Physicians or social workers (who are not normally on the staff of these stations) should be asked to participate as required. The management of the station is to be in the hands of a qualified professional with organizational aptitude and, as a rule, with additional training in community health services or their equivalent. The manager is responsible for securing the required teamwork, contact with sponsoring agencies, and professional supervision of the staff, which includes coordination of the staff and planning for continued training.

The "hospital-at-home" plans that have been developing in a number of countries in the Region constitute a much needed bridge between the hospital and community or primary care. They also raise certain problems for management and decision-making. They usually involve the hospital (in some places requiring previous hospital admission) and may also require the agreement of the patient, and possibly that of his family doctor and the hospital doctor. A report from a social worker on the patient's home conditions may be needed and, where insurance coverage is involved, the medical advisor of the insurance agency or social security office may have to give his consent. The hospital services may have to be supplemented by other community services. This need for multidirectional coordination creates a number of potential sources of friction, especially between the hospital and the family doctor (*15*). An effective organization within the hospital but with close liaison with the other agencies concerned, or a coordinating agency in the community but with close links with the hospital, is an essential prerequisite for the success of such projects.

Strategies for new health centres

In countries where a policy for the establishment of health centres exists but is only gradually being implemented, the erection of new centres requires careful preparation. Where a health centre replaces traditional

general practice it changes the pattern of care for the community, the pattern of practice for the providers of care, and usually also the respective involvement of various authorities. The watchword in approaching plans for a new centre is therefore "consultation". Examples of such strategies are provided by studies in Scotland (*16*) and Sweden (*11*).

In Scotland the project begins with the appropriate health board identifying communities that might be served by additional health centres. Before the creation of the health boards, the initiative for a new centre came from various local sources, usually local general practitioners. The sequence of events is then as follows:

- agreement in principle that a health centre should be built
- preparation of and agreement on a functional brief
- identification, investigation and acquisition of a site
- preparation of and agreement on schedules, leading to provisional costings
- sketch plans
- working drawings, final costings and rental agreement
- appointment of building contractors
- building
- commissioning and completion
- evaluation.

It is at the initial stage, i.e. reaching an agreement in principle, that broad consultation is initiated. In Scotland, this involves the prospective providers of services (general practitioners, dentists, pharmacists, hospital consultant staff, diagnostic and rehabilitation services, social services, and community medicine specialists). Also included in the discussions are the local planning authority, education authority, professional advisory committees and the local health council. If this results in an agreement in principle that a health centre be built, and on the population to be served and the services to be provided, then a project team is set up by the health board.

The project team will include members of the staff of the health board but membership will vary according to the stage of development. Consultation will be carried out throughout the development with general practitioners, dentists and pharmacists as potential users of the centre. The team will be responsible for carrying forward the project until the centre is fully commissioned. This will be done in close collaboration with a central government agency responsible for all construction work. The agreement in principle will then be translated into more specific descriptions of services to be provided and of the building design, to be incorporated in a functional brief. There will then follow the other stages mentioned above until the centre is commissioned for use.

Scotland thus has a standard procedure for the development of new

health centres and a clear policy regarding the functions and functioning of a health centre. The situation leading up to the establishment of a health centre in the Swedish town of Tierp was somewhat different, owing to the deliberate introduction of more experimental elements and the involvement of research groups aiming at evaluating the various features of services provided to the target population before and after the erection of the new centre.

The preparatory work, therefore, as well as the ongoing monitoring and evaluation of the centre, were shared by the administrative agencies concerned with the centre's operation—Tierp Municipality, Uppsala County Council and the National Board of Health and Welfare—and the research institutions at Uppsala University, the College of Social Science in Stockholm, and the Swedish Planning and Rationalization Institute of the Health and Social Services (SPRI). The three administrative agencies formed a collaboration committee, responsible for the management and coordination of the project work. Members of the research institutions, together with representatives from the National Board of Health, the head of the social welfare office, the registrar and the local chief education officer, comprised the reference group and directed the developmental work of the centre.

The aim of the project was stated as the application of "the totality concept to the experimental activities, thereby contributing to the coordination of social welfare, public health, medical care and student care" in the municipality.

The preparatory work is described as follows (*11*):

> Work on the Tierp project started during the fiscal year 1970/71. During the next few years, guidelines were drawn up for work on the project, various introductory studies were carried out, and the research activities were started. In the spring of 1971, a number of information and training activities were also started. During the early stages, this work was primarily concerned with disseminating information on the content of the Tierp project to the various parties involved, and arranging for training in matters of cooperation. In the spring term of 1973, a four-term course on social and behavioural science was started. The course participants comprised elected representatives, and municipality and county council employees.
>
> The head of the social welfare office of the new municipality took up his appointment on the 1st February 1973, and up to the end of the year, he was engaged in preparatory work for the re-organization.

The health centre premises were ready on 1 April 1974. It should be noted that the creation of the health centre, which brought together several scattered rural practices, went hand-in-hand with the administrative consolidation of several small communities.

The preliminary studies mentioned concerned topographic, demographic and economic characteristics as well as an inventory of the various community services; an important aspect was that the attitudes and opinions of the population and the personnel affected by the change were ascertained.

Conclusions

The *scope* for management decision in a health centre is determined primarily by the degree of its autonomy within a particular health service system. Management *style* is a function of the extent to which the internal organization is hierarchically designed, either by the system of which the centre is a part, by the sponsoring agency, or simply by those managing the centre. In the European Region, this ranges all the way from very strong community and staff participation to strictly hierarchical line responsibility and accountability within the centre, and between the centre and other levels of the system.

In countries where health centres form an integral part of a public health services delivery system on a regionalized basis, the roles of management and decision-making are clearly defined. This applies to the socialist countries. Finland and Iceland represent systems that have also developed a clear pattern for the management of their health centres. The same is true for the new national health service in Portugal and for those primary care facilities that constitute health centres in the technical sense, as distinct from the more independent group practices in the United Kingdom. Sweden, on the other hand, is developing different modules which are being carefully monitored and evaluated; one of the problems there is to reconcile the local community responsibility for social services with the county responsibility for health services. To the extent that health centres exist as part of a national health system in Turkey, there too health centre management is integrated into the centrally directed system. In most other pluralistic systems in the Region the various forms of group practice are subject to private decision-making and management, although governments encourage its development in principle. For instance the Federal Ministry of Health and Environmental Protection in Austria has said that the government intends to lend material and ideological support to the idea of group practice, particularly in areas with insufficient doctors, as a means of improving health services and also to counter the rising cost of hospital care (*17*). The WHO Regional Director for Europe has summed up the situation as follows (*18*):

> The notion is growing in Europe of the health centre or polyclinic as the physical centre for PHC [primary health care]. However, "health centre" still suggests narrow curative care and such centres are invariably run by physicians without much help from other health workers or consumers. The notion of a PHC team with differing skills, each appropriate to some of the needs and demands of the population and all working together, is rarely put into effect.

In the same review of the European scene, the generally very limited extent of community participation in the provision of primary care is noted, as seen in the light of the principle that community participation is essential in primary health care: "A general problem in the European Region is that of community non-participation in medical care. In our Region the physician remains supreme in all, or most, fields of health

care and the community usually respects this arrangement". As concerns a management role of the various members of the primary care team, a WHO symposium on nursing services (*19*) thought it important that nurses be taught the techniques of personnel and financial management, and it was concluded that "permanent posts should be established for nurse managers at hospital, health centre and community levels to ensure that nursing policies are well defined and implemented". On a broader plane, the need for appropriate training in health planning and management at all levels was considered to be urgently needed to implement the strategies for "health for all by the year 2000" (*5*).

Community participation in the provision of primary care was extensively discussed in the context of the 1978 Alma-Ata Conference. These issues will be further reviewed in a subsequent part of this report within the larger framework of the relationship between the primary care facility and the population served. It should be remembered here, however, that this touches on the question of what constitutes the community and who speaks for it. In many of the health care systems in the Region, where health centres form a part of the system, the elected representatives of the community or committees appointed by them exert some sort of monitoring or supervision over the operations of the health centre, although in practice this role often seems restricted to a review of the centre's budget. In some situations, the community input is greater at the planning than at the operational stage, but the reverse also occurs.

Monitoring and evaluation is a tool either of the internal management of a centre or of a higher supervisory level. In this regard the above mentioned report by the Regional Director observes that in the Region "health care systems are not regularly evaluated, and innovation and change, when they come, are the result of highly specialized political decisions rather than systematic analyses, scientifically based though these may be". Because of the generally limited scope of evaluation activities, "unfortunately, in the European Region it is only in the field of drug evaluation that effectiveness is rigorously and regularly tested". While routine evaluative mechanisms may be scarce in the Region, considerable research in this area is being carried out in Sweden and the United Kingdom. However, a built-in process of evaluation was seen as essential at the Alma-Ata Conference (*6*). It is to be carried out at several levels: "by those providing the services, those using them, and those responsible for managerial and technical control at the different levels of the health system". The objectives of the evaluation process are described as relevance of the activities, progress in relation to plans, efficiency, effectiveness, and impact on the overall socioeconomic development of the community. These objectives are similar to those listed by Roemer (*20*) as areas for the evaluation of community health centres. He describes a programme for prospective evaluation as well as methods for retrospective research. A good deal of evaluative research on group practice and health centre services has also been carried out in Canada and the United States.

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7

Organizational structure

Structure, for the purposes of this discussion, will be seen as a concept and as a component of the larger system structure, rather than in terms of specific characteristics of the physical setting.

The health centre, whether conceived as a physical structure combining diverse primary care services under one roof, or as a concept aimed at ensuring the coordination of such services wherever located in the community, fulfils a function corresponding to that already established for inpatient care in the hospital. There is, however, no clear dividing line between these two types of institution. Hospitals may provide direct-access ambulatory care in their outpatient departments, while health centres may provide not only a broad range of specialist services—as in the polyclinics or the multispecialty group practices in North America—but may also have beds attached, as in the Finnish and Portuguese health centres or some clinics in France. Such beds may be used either for very short stays or, on the other hand, for chronic patients not requiring the elaborate services of an acute hospital and who should be accommodated close to the community in which they reside.

Health centres may comprise the entire primary care team or, in countries where primary physicians are independent agents, provide back-up for private general practice, as in the case of the *Sozialstationen* in the Federal Republic of Germany. The identification of health centres with the usual concept of primary care has become difficult where specialists practise in such centres or where inpatient facilities are attached to them. Another indication of the fluid borderline between primary and secondary care is presented by centres providing comprehensive services for certain groups of patients or for certain conditions, as in the case of dispensaries in some health care systems.

The physical structure may be a purpose-designed building or one converted for that purpose, the latter finding more favour recently as a measure of cost containment. Different administrative structures have been described earlier in the context of management patterns. These are determined to a large extent by the prevailing health service system: where there is a national health service, the individual centre becomes

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part of the national or regional organization; elsewhere, centres may operate as enterprises of the doctors sponsoring the centre or group, or they may constitute facilities provided by private organizations, sick funds or trade unions, either as non-profit organizations or as businesses. In countries with mixed economic systems, primary health care facilities may occasionally become part of the local administration.

Legislation providing for the establishment of health centres is, as a rule, confined to requiring the authorities concerned—local or regional—to establish centres. Technical specifications or guidelines are provided by special branches of government concerned with the design of health facilities. Statutory provisions frequently stipulate only the services to be provided. This has been described in Chapter 6 with regard to the Finnish Public Health Act. The British National Health Service Act of 1946 also defines only the functions of the proposed health centres, i.e. "the provision of facilities for all or any of general medical and dental services, pharmaceutical services and services for hospital out-patients, information, and any other services provision of which was made a function of the authorities". Since the construction of new, purpose-built centres progressed only slowly in the United Kingdom, a committee recommended in 1950 that consideration be given to the conversion of existing rather than the construction of new buildings, a trend re-emphasized in more recent government policy statements establishing priorities for the health and personal social services in the light of financial constraints.

How then do we know a health centre when we see one? In proposing a health centre policy for Canada, Hastings (*1*) sees the following as criteria for a community health centre.

> A facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality:
>
> — in an acceptable manner,
>
> — through a team of health professionals and other personnel,
>
> — working in an accessible setting,
>
> — which is well managed, and
>
> — part of a responsive and accountable health services system,
>
> — closely and effectively co-ordinated with the social and related services to help people, families, and communities deal with the many-sided problems of living.

This, of course, is dependent on the existence of a responsive and accountable health service system, approaching the desiderata that emerged from the Alma-Ata Conference. It fits into the general picture of general practice that developed leading up to that Conference: "primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford" (*2*).

Most of these characteristics, however, concern principles rather than operational features of the structure of health centres, and only very few primary care facilities in the European Region can as yet aspire to all the ideals expressed in these statements. The few that do approach these aims are the result of the work of highly motivated individuals in the community or professionals in a centre, rather than national strategies.

One of the elements in a structured organization of primary care is the combination of skills and disciplines that distinguishes it from the solo practice of medicine. While some people see health centres not only as medical facilities but also as a force for social development in the community, others stress the advantages organization has for the application of scientific advances and modern technology. Solo practice is seen as giving way in Europe to practice in groups or health centres in a post-industrial society, where progress is determined by science rather than industry (*3*).

The organizational structures of primary care found in the pluralistic systems of the Region have their counterparts in similar systems elsewhere. Apart from the various forms of free-standing group practice, including those providing comprehensive care to prepaying subscribers (health maintenance organizations), there are arrangements whereby hospitals lease offices to physicians (*4*) or, as in New York City, whereby the outpatient clinic of a former municipal hospital was affiliated to a voluntary hospital (*5*). In their health maintenance organizations the Americans have been more successful than some of their pluralistic European counterparts in providing a range of comprehensive care structures for the populations they serve. They too are not bound to any particular physical structure, as long as coordinated services can be provided both inside and outside the hospital. While the prepaid group practices, usually multi-specialty clinics, served to originate the concept of the health maintenance organizations, the latter are much more flexible in their structure and also include other forms of practice which may be sponsored and managed by consumer groups, physicians, private businesses or public agencies, medical schools, employee organizations or others. Some own inpatient facilities, others are under contract to them. Physicians may be employed on a salary basis, possibly modified by various incentive payments, whereas others have contracts with individual physicians or groups on a fee-for-service basis. In systems where physicians, and general practitioners in particular, practise as independent agents and therefore choose the structure of their practice, their attitudes towards grouping their practices is an important factor in developing various organizational structures for the provision of primary care. In most countries, professional medical organizations have abandoned or at least relaxed their opposition to group practice, and legal obstacles have been gradually removed. There are signs that young physicians show a more positive attitude towards grouping, and also to accepting salaried positions where fee-for-service remuneration still remains the traditional form of payment. In Canada, for instance, a study (*6*) has shown that

among young physicians 21% had entered solo practice, 57% had joined a group practice or partnership, and 22% had taken various salaried positions including those in universities and government. On the other hand, a study in one of the metropolitan health regions in Sydney, Australia—which of course is not representative of national trends—suggested that "a large proportion of the new practices which have been established in the region in recent years are solo practices" (*7*).

Structure and the system

The variation found in the European Region in the structure of primary care organization is illustrated in the following examples from differently conceived health care systems in the Region.

The socialist countries of eastern Europe

Managerial lines of responsibility described in Chapter 6 closely reflect also the structural position of primary care facilities within a particular system.

In countries with a national health service and an insignificant private sector, primary care facilities are integral parts of the entire structure, laterally as well as vertically integrated into the larger system. This is most evident in the USSR, as in the other socialist countries of eastern Europe, with its network of polyclinics, outpatient clinics, maternal and child health clinics, dispensaries and feldsher–midwife posts, as well as the corresponding industrial clinics, all liaising with the *sanepid* stations. This is reflected in the levels of the respective physical facilities, ranging from the feldsher–midwife post with only basic accommodation (waiting room, consulting room, examination room and treatment room) to the sophisticated multispecialty polyclinic attached to a rural *učastok* hospital with its support services, covering a general or industrial population of about 50 000.

Bulgaria has a proportionately high rural agricultural population. It therefore structures its primary care facilities to the requirements of small outlying communities, with the aim of providing services according to the required levels. The most outlying units, serving communities of up to about 2000 people, are the medical assistants' health centres, which provide services prior to the intervention of a doctor. These may be administratively attached to a larger institution in the vicinity, and they may take care of about half the primary care needs in the community. Larger communities of about 1500–4600 people are served by a village public health sector, which may include in its administrative structure one or more medical assistants' health centres or, on the other hand, be itself a branch of a larger village institution in the area. One or more communities with about 4600–6000 people have a village public health service, and those with over 6000 people are served by a branch (village) polyclinic. These clinics provide general practitioner services as well as paediatric, gynaecological/obstetric and dental care. They are

also visited twice weekly by other specialists, including neurologists, ophthalmologists and ear, nose and throat specialists. The structure of urban facilities is based on the principle of the "integrated therapeutic sector" for populations of up to 3000. Correspondingly, there are "workshop therapeutic health sectors" for establishments with 2000 or more workers; these may be located in the health centre at the establishment or they may form part of a polyclinic. There are also "integrated paediatric sectors", each covering about 1000 children up to 15 years. In addition to these general medical facilities there are stations, departments and units for emergency medical aid which, in cities with 200 000 or more people, may operate as independent institutions or be attached to polyclinics or integrated district hospitals. New structural units of urban polyclinics are the dispensaries, which aim at screening and early disease detection. These are staffed mainly by middle-level medical personnel and technicians. Detected cases are referred by them to the appropriate sector physician.

In Czechoslovakia the development of primary care services has been strongly stimulated by the 14th and 15th Congresses of the Communist Party of Czechoslovakia. The tendency now is to build joint health–community centres, chiefly in rural areas, and polyclinics mainly in the larger towns. There is a trend towards the consolidation of rural centres in line with the concentration and integration of farm cooperatives into larger units, so that the health–community centres are established in localities that are also rural administrative centres. The larger consolidated centres may accommodate 2 or 3 physicians and staff and house such specialized services as a biochemical and dental laboratory, physiotherapy and pharmacy. A paediatric clinic may be established separately, and emergency services and transport are also available. These centres do not contain beds since there are sufficient hospital facilities available and accessible. Some centres are still located in old, adapted buildings, but these are being replaced by new purpose-built facilities which are modern, well equipped and rationally situated. For both health centres and polyclinics there are norms regarding building and equipment and there are model designs developed by a special branch of the Ministry, which are adhered to as far as possible. The administrative personnel of the centres are not part of the primary care service, but are the responsibility of the agencies concerned with financial and technical matters.

In the German Democratic Republic the primary care facilities range from rural nurses' stations (*Gemeindeschwesternstationen*) to polyclinics (*8*). Besides these there are, as in the USSR, dispensaries dealing with specific categories of health problems and follow-up.

In Hungary one finds, in communities large enough to have more than one general practitioner, offices located in one building as the "central district doctors' offices", usually accommodating 3–6 doctors as well as housing the group leader and the dentist's office. Also available here may be a small laboratory, ECG equipment, and in most cases also a small pharmacy. In larger centres certain specialized services such as

paediatrics, gynaecology/obstetrics and physiotherapy may be included in these offices. To consolidate them into larger centres would be impractical in many rural areas at present because of transportation difficulties. Centrally organized on-duty teams provide services at weekends and during holidays. Ambulance services are available locally but administered nationally. In Budapest the Health Act of 1972 continued the earlier trend towards integration of the various curative–prophylactic services, although certain specialized services that have nationwide functions remain under the Ministry of Health. Institutions serving a single district of the capital are managed by the district councils, while those serving several districts fall under the competence of the Budapest City Council. Future development aims at the integration of hospital-based polyclinic services for several districts of the capital, but in all its plans for the integration of services in the Health Department, the Executive Committee of the Budapest City Council stresses the dynamic nature of health planning and concludes that "perfectly identical organizations can nowhere be established. Differences exist not only in the size, structure or site of the institutions, but also their tasks vary considerably" (*9*). That statement has universal validity with regard to the organization of health services.

In Romania, the peripheral primary care facility is the general practice dispensary, hierarchically integrated with the polyclinic and, in turn, with the territorial hospital from which the health services within its area are directed and integrated according to the plan. Parallel dispensary services are provided for industrial establishments and schools. The institution of industrial clinics and categorically oriented dispensaries is a common feature of the socialist health care systems, as are the levels of regionalized facilities, although the terminology varies.

The peripheral primary care institutions in Yugoslavia are the health stations for the general population and those for industrial establishments. The next level of care is provided by health centres. Their structure varies somewhat between the republics, which exercise a fair amount of autonomy in health matters within the country's federal constitution; a substantial degree of managerial autonomy is also left to the individual institution. The health centres, in addition to providing general and some specialized medical care (including domiciliary and dental care), also monitor the health of the population in the area, organize health educational activities, and supply such services as disinfection and disinfestation. In some of the republics health centres have beds for certain inpatient services, while these are expressly forbidden in other republics. Other specialized services may be provided based on local administrative arrangements and subject to the existence of separate dispensaries for certain categories of disease or patient. There may be independent dispensaries for preschool children, school-children, women and industrial employees, or such health problems as tuberculosis, skin and venereal diseases, cancer, trachoma, mental disorders, and other chronic conditions (*10*).

The above descriptions indicate the important basic similarities

among the socialist countries of eastern Europe in the structure of their primary care facilities: the hierarchy of levels of institutions, the special institutions for the care of industrial workers, and the dispensary concept in some form or other. These basic features, however, are adapted by individual countries to meet particular needs, such as those of small and often remote rural communities.

Other European countries with a national health service

Finland's health centres share with those described above a structure based on centrally stipulated standards. The concept here is not tied so much to the physical facility as to the effectively integrated provision of the services provided for in the Public Health Act of 1972. Paragraph 15 of that Act states that the functions of the health centre may, as need arises, be assigned to subsidiary reception premises or be arranged by means of mobile working units. To obtain the optimum population of about 10 000–13 000 for a health centre, local communes are given the opportunity to form federations. With the consent of the National Board of Health, a commune may also agree with a neighbouring commune for the latter to manage some of the public health work for some part of the former commune. As pointed out earlier, the term "health centre" here means an administrative and functional entity, but the different service units need not always be located under the same roof. Indeed, apart from having outlying satellite units, a health centre may comprise what were formerly maternal and child health units located in the community, facilities used by the former communal medical officers, and small local inpatient units. The present policy is, however, to bring these various units under one roof (*11*). It was also decided that health centres should have inpatient facilities – about 30 beds for acutely ill and about 60 beds for chronically ill patients. The former would require only short stays; the latter, requiring less intensive care, would benefit from maintaining contact with their community (*12*).

In commenting on the structure of the Finnish health centres, Stephen (*13*) mentions their superb planning and the high quality of the facilities, which appeared to him "almost extravagant" and thus perhaps would not leave sufficient funds to complete the network on the same basis. Laboratories, for instance, are necessary in remote stations but in urban areas they could be centralized in local hospitals. Härö (*12*) points out, however, that health centre laboratories could eventually also assume environmental monitoring functions such as food and water hygiene.

Iceland also has the rural areas well covered by health centres. There are few in Reykjavik itself, but doctors there tend to form partnerships or group practices. In many of the rural areas small cottage hospitals, now defunct, have been converted into health centres. In a number of places the health centre is linked to the outpatient clinic of the hospital, and some centres have been built adjacent to the hospital or integrated into its physical structure. In the capital some health centres are also

planned as part of an outpatient clinic of a hospital, while others are linked to a hospital functionally so that they can share laboratory and other facilities. In 1976, the Ministry of Health and Social Security issued a manual on the planning of facilities for the health services. It gives instructions on preparing an architect's brief, together with sample arrangements of different functional units and examples of health centres recently built.

Some health centres in Iceland have resident nurses rather than physicians, the latter holding surgery hours only once or twice a week. X-ray equipment is installed wherever it is not readily accessible in a hospital. Every centre has a small laboratory with simple equipment, but most samples are sent to the nearest hospital. In each rural district there is a drug dispensary on the premises. In the urban areas pharmacies are located in the vicinity of the health centre, but plans for new centres provide for the pharmacy to be located in the centre or adjacent to it. All centres are equipped with standard diagnostic facilities. In urban areas there may be specialists on the staff with their own special equipment. Where, as in the rural areas, specialists visit centres regularly, such equipment may be kept on the premises or, depending on the frequency of visits, brought from the central hospital.

Waiting rooms in health centres in Iceland are geared to the number and working patterns of the physicians. Large waiting rooms are avoided and in most centres the appointments system is the general rule. There are separate rest rooms for men and women, and at least one lavatory for the handicapped is planned for each new centre. Centres are located as centrally as possible, and care is being taken to facilitate access for the handicapped.

There is less uniformity in primary health care organization in the other Nordic countries, where various patterns are being employed and observed. In Denmark about half of the general practitioners work in groups, generally comprising 2–7 practitioners. In Norway the establishment of social-medical centres has met with political and professional resistance, but informal coordination among the various agencies concerned with primary care has been widely experimented with and a number of proposals are being considered (*14*). Nevertheless, there are some centres in operation. Two areas where there is a shortage of general practitioners are the northern areas and the city of Oslo. A medical school has been established at Tromsø with the aim of relieving under-doctored areas in the north. There is a health centre serving a population of about 15000 in the northern town of Alta, whose staff includes seven physicians, nurses, public health nurses, social workers and ancillary staff. It has a pathology laboratory, an X-ray unit, physiotherapy units, a day hospital with occupational therapy, and inpatient beds. The strategy for Oslo includes the provision of good working conditions for general practice in centres for about 12000 people, with a staff of five general practitioners, support staff and social workers (*15*).

In Sweden primary care facilities range from the remote outposts

housing district nurses or, in many rural areas, single-handed general practitioners, through small centres with 3 or 4 physicians and other team members, to larger centres with general practitioners and some specialists. The underlying principle is to link the staff in the smaller units in a district to the larger health centres. Some larger health centres have been created that include offices for the social services. Some of these centres in rural areas, such as that in Tierp, are the result of the consolidation of several rural practices; others, like that in one of the new residential suburbs of Göteborg, are designed to bring coordinated health and social services to the residents of large new housing estates.

In the United Kingdom, the health centre is only one of the forms of group practice in the National Health Service. The term "health centre" is reserved here for purpose-built or restored facilities, designed in accordance with national guidelines, and operated under the auspices of the health authorities. In a discussion paper released by the then Ministry of Health in 1944, preparatory to the legislation for a national health service, the government declared its intention to design the new service so as "to give scope to a full trial of this new method of organising medical practice, and so as to enable it to be expanded and developed as time goes on to the maximum extent which the practical experience of its working is found to justify"(*16*). The design was broadly envisaged to provide for individual consulting rooms, reception and waiting rooms, simple laboratory work, nursing and secretarial staff accommodation, telephone services and "other accessories" as well as, according to circumstances, recovery and rest rooms, dark rooms, facilities for minor surgery, etc. In a review of the first year of the new national health service an independent journal, The *Practitioner*, saw the danger of local health authorities producing plans for health centres "which could not possibly receive the approval of experienced medical men" and therefore close cooperation with the doctors was considered essential (*17*): "it is obvious that lay members of a local authority will be more impressed by the need for the provision of such things in the centre as canteens, and toddlers' rooms in which children can wait while their mothers consult the doctor; but it is the working convenience of the doctor and nurses which should receive first consideration in any plan for a health centre. The health centre should be a working institution and not a kind of club for the congregation of people for social intercourse with their friends". That these views did not represent the general consensus even at that time in England is shown by the existence then of the Peckham Centre in London, which was designed to integrate health care as much as possible into community life. At present, health centres in the British National Health Service are defined as "premises provided by an area health authority where primary health care services are provided for patients by general medical practitioners, health visitors and district nurses and possibly other professions" (*18*). A health centre in the technical sense is a purpose-built physical facility provided by a health authority and fulfilling certain specific requirements. However, the government authorizes health auth-

orities to use capital funds to promote the objectives of health centres in a variety of ways, in addition to purpose-built centres. First of all, if not purpose-built, existing premises may be converted for use as health centres. Or, where health service buildings already accommodate district nurses and health visitors, general practitioners' premises may be added. If this is not possible, nursing and other primary care services may be located near to general practitioners' premises, but such accommodation should be capable of adaptation or expansion to eventually house all services. Alternatively, general practitioners may be financially assisted in adapting their own premises to accommodate other members of the team (*19*). The same government directives comment on the size of health centres:

> In normal circumstances, particularly in urban areas, health centres should not be provided that would be used by less than three family doctors as their sole or main surgery: with a smaller number the full potential of a primary health care team is unlikely to be realized. A health centre accommodating fewer than three doctors may be provided if the Area Health Authority is satisfied that this is the most effective way of meeting the needs for primary health care services in the locality.

In rural areas travel distance may be a case in question, or in deprived urban areas the need to provide one or two doctors with adequate premises. But to avoid an impersonal, institutional atmosphere health centres should not be too large:

> These considerations will usually suggest a centre of not more than twelve general practitioners (the present average is five). In the larger centres practitioners would usually be grouped in two or more separate practices. Even so large centres may limit accessibility, endanger informality, and create difficulty in the organisation of primary health care teams.

In densely populated urban areas, however, sites may be expensive and difficult to obtain, and the circumstances will thus favour fewer, larger centres. But care must be taken in such cases in designing the centre "to maintain the individuality of practices and to promote an informal atmosphere". The location of a health centre should be decided in consultation with the Community Health Council in order to ensure optimal accessibility, and public transport should be coordinated. And, of course, the doctors expected to practise in the centre will have some say regarding its siting. Close proximity to a hospital has many advantages but the identity of the centre must be clearly preserved: "patients should not be given the impression that they have to come to hospital to consult a family doctor". The British Medical Association, on the other hand, would like to see experimentation with a division of primary medical care within a hospital (*20*). Doctors in such a division would see their patients as in any other setting and do some home visiting while, at the same time, having ready access to the hospital and their specialist colleagues. The report also discusses other aspects of primary care facilities in greater detail.

A study of British health centres (*21*) dealt with various aspects of

health centre design. Among them is the choice of a single or divided reception and waiting area. The former is less expensive, easier to supervise and more flexible if the centre is expanded. If they become large, however, waiting rooms may confuse patients and may be impersonal and difficult to manage; they may have to be divided where consulting rooms are on different floors. Shared consulting and examination rooms reduce cost but depend on schedules that do not overlap. Staff common rooms may be for all categories of staff to promote good relationships, or doctors and nurses may have a separate room to facilitate case discussion.

Most health centres, the study found, are one-storey buildings, but the size and siting of the centre may dictate otherwise. In one instance of a two-storey building (*22*), the ground floor contains reception, consulting and examination rooms, waiting rooms for each practice, a treatment room, a dispensary, and lavatories, as well as clinics for maternal and child health and dental services. Upstairs is the administrative unit and a conference room. Another two-storey centre also places dental offices upstairs. The principles underlying the design of this centre are formulated as follows:

(*a*) accommodation and staff should be shared and no room provided that would not be used for at least ten hours a week;

(*b*) contact between patient, nurse and doctor should be facilitated, e.g. by their interrelation between the examination suites and a treatment area staffed by health centre nurses, but also used by the locally based home nursing team;

(*c*) the building must be capable of 10% expansion;

(*d*) the building must be capable of functional change; and

(*e*) there must be a common meeting place where all staff using the centre can meet informally.

The low percentage of general practitioners working in health centres, after some 30 years of government policy in favour of such centres, can be attributed to a variety of reasons. One is the recurring shortage of funds to meet the capital cost; another is a reluctance of general practitioners, who in the United Kingdom still contract independently with the National Health Service, to practise under closer scrutiny of the health authorities. Both reasons are behind the government's willingness to support also other forms of organized practice. To allay the apprehension of its members, the British Medical Association has suggested that health centres be owned not by the health authority but by an independent non-political body, which would also negotiate agreements with general practitioners wishing to practise in health centres. The advantages to doctors of converting existing premises have been described by some of the doctors involved as two-fold (*23*): first, the government obtains centres for less than the cost of purpose-built centres and, second, the partners have a stake in their own future and no government control. Another group of doctors have

described how they were able to finance independently purpose-built premises for their group, which they found "professionally and financially rewarding" (*24*). The Royal Commission on the National Health Service, however, finds that in some situations a formal health centre is preferable to attempts to support group practice. Specific recommendations in that regard are:

— the health departments should consider urgently measures to assist the development of health centres or other suitable premises, to attract general practitioners to London and other inner city areas where sites are particularly expensive or difficult to obtain; and

— health authorities, when establishing health centres in inner city and deprived urban areas, should experiment with offering salaried appointments and reduce list sizes to attract groups of doctors to work in them.

In comparing health centres in Finland and the United Kingdom, Kekki (*25*) observed that unlike its British counterpart, the Finnish health centre is not regarded merely as a purpose-built centre but as an institution which is also responsible for activities outside the building itself. He also comments that Finnish doctors working in health centres visit patients' homes less often, and that beds attached to Finnish centres are 60% cheaper than those in a central hospital.

In Scotland too, as in the United Kingdom in general, the health centre is identified with a building used by one or more primary care teams, and designed as a base for the delivery of health care to a defined population (*26*). The design guide issued by the government deals with general principles, factors affecting design, site considerations, arrangement of space, construction and dimensions, supplies and stores, furniture and equipment, and staffing. Among points specifically mentioned are an easily identified entrance and, important but now always considered, a covered shelter for baby carriages that can be seen from within the centre. There are to be provisions for the handicapped and the usual spaces for waiting, consulting, examination and treatment. Provision is to be made for future expansion. In addition to a general waiting area, there are sub-waiting rooms. Regarding one particular centre in the city of Glasgow it is mentioned that site limitations dictated the creation of a two-storey building, the upper floor to contain a university unit for teaching and research, offices, a seminar room, staff rooms, and the dental service area. Special attention was given in the design "to the need to safeguard against the creation of a large impersonal building in which patients would lose all sense of privacy and the work of doctors would be disrupted by noise" (*27*).

In Turkey, in those areas covered by health centres as part of the national service for otherwise underserved parts of the country, the Ministry of Works erects primary care facilities on behalf of the Ministry of Health. The sites and buildings belong to the State and are put at the disposal of the Ministry of Health by the Ministry of Finance. There are four types of such facilities, according to the location and size

of the population served: *ocak* type Al for populations of about 50 000; *ocak* type D1 for populations of about 20 000; rural types for villages with about 10 000 people; and health stations for populations of about 2000–3000. Major equipment is purchased locally with funds provided by the Ministry. Transport by motor vehicles is also provided to the *ocaks* by the Ministry, or it may be hired by them. Corresponding facilities exist for maternal and child health care. Health centres in Turkey are attached to inpatient facilities with from 10 to 25 beds, and include laboratory and pharmacy services as well as diagnostic and treatment equipment.

In the western reaches of the Mediterranean, Algeria has restructured its primary care organization in the city of Oran, formerly characterized by an uneven distribution of primary care facilities with different functions. Now the service is strictly regionalized, with each unit serving a defined geographical area. These units are polyvalent in that they provide not only consultation and treatment, but also immunization of children, prenatal consultation, family planning and school health services, dental care, and other public health services (*28*).

In this account of national health service systems it should be noted that these do not always provide just one channel for primary care; special services may be offered, often in separate facilities. In the socialist countries this applies to occupational health, maternal and child health and dispensary services. In Finland the tuberculosis and mental health services are still largely separate from the mainstream of primary care. Dental services are often operated in their own premises. In many countries centres or clinics run by voluntary organizations cater for special needs, such as those of young people for treatment or advice on a more personal and confidential basis than might be expected from public institutions. Furthermore, in most of the countries with a national health service there also exists a private sector, albeit more or less limited in scope. In this sense the health service systems of most countries of the European Region are not entirely monolithic.

Pluralistic health care systems

These are systems where the role of the public or quasi-public sector is mainly confined to the financing of services and the resulting powers of control and regulation. It follows that the public system is limited to clinics providing preventive services, maternal and child care, and possibly school health supervision. There may be dispensaries for case-finding directed at certain disease categories. Such services are largely of a diagnostic nature, findings being transmitted to the patient's own doctor. There are such quasi-public facilities as outpatient clinics of hospitals, university clinics, or clinics operated by social insurance agencies (such as the *Ambulatorien* in Austria) or polyclinics under political or religious auspices, as in Belgium and the Netherlands. In general, however, the organization of their practice is largely up to the practitioners concerned. This may vary from being located in a common

building, where each physician is responsible for his own practice, to collective practices with ready substitution and referral within the group together with shared equipment and ancillary services.

Belgium has about 20 *centres de santé*, the result of a growing tendency, especially among recent graduates, to associate themselves with colleagues and other health workers. Among the constraints inherent in this sort of organization, according to the government, are: absence of responsibility for a defined population; lack of incentives for extension activities such as prevention, health education and provision of supportive social services, and problems of financing of ancillary personnel. Hence, domiciliary services are very limited.

In countries with a federal constitution, such as Austria and the Federal Republic of Germany, public health facilities are provided by each state rather than by central government. In the Federal Republic of Germany, physicians in private practice who contract with sickness insurance funds for services to their members are advised by their professional association that modern medicine cannot be practised without some resort to teamwork and cooperation (*29*). There are traditional informal types of cooperation such as mutual referral, consultation and substitution, and there is a variety of formal arrangements. The main types among the latter are the collective practices (*Gemeinschaftspraxen*), practice communities (*Praxisgemeinschaften*) and laboratory or apparatus communities (*Laborgemeinschaften, Gerätegemeinschaften*).

In the collective practices the members, usually from the same or an allied field of specialization, carry out their profession as a team, and accounting is done for the group as a whole. Finances are pooled and profits shared. This type is common between older and younger practitioners, sometimes from the same family, where the experience of the older members is complemented by the up-to-date knowledge of the younger. The practice communities may comprise doctors from the same or different fields of specialization, who share certain facilities or pool their staff but who work on their own account. In the laboratory or apparatus communities, doctors join forces for the common use of technical medical equipment and the services of the necessary technical personnel, but otherwise practise independently. These communities may be internal, i.e. under the same roof as the participating practices, or external, i.e. in separate locations.

The collective practices create certain accounting difficulties, especially with insurance carriers, but not so the other forms of practice organization. Practice structures may also be classified as "ambulant", where doctors are independent agents, "stationary", where doctors are employed by an institution, or "public", where doctors are civil servants. Multispecialty groups have faced problems in getting legal sanction, but the principle is realised also in university polyclinics.

The general practitioners' association in the Federal Republic takes a cautious approach to these developments. In its discussion of the issues involved, the association asserts its willingness to promote these various

forms of practice community as long as they do not violate the principle of patient-oriented care by the family physician. The association is particularly anxious to stimulate the development of laboratory communities, because it sees such rationalization of the use of these services leading to reduced costs and thus financial advantages for the doctor. Other medical-technical centres and data banks, however, if they are not designed to satisfy the needs of the patient, are frowned upon by the association because they could imperil confidentiality.

In 1977, only about 5–10% of practising physicians in the Federal Republic were in collective practices with two doctors, often father and son, and there were some 250 practices with anywhere from 3 to 50 or more doctors. About 6000 doctors participated in laboratory communities.

An entirely different form of structure of primary care organization in the Federal Republic (and similar institutions exist elsewhere in Europe) is represented by the *Sozialstation*, which is available to physicians but without their direct participation. These stations are variously referred to as centres for social assistance, medical community centres, or centres for community assistance. They provide nursing and various social services both at the station and in patients' homes. There are no physicians practising in the stations but local physicians refer patients to them. Guidelines in one of the states of the Republic define these stations as providing certain professional health and social services by teams within a defined area, supported and supplemented by voluntary effort. Their remit is to offer the population of the area comprehensive and continuous care for the sick, the elderly and families, with a view towards preserving the independence of every citizen in his home environment and to limit hospital or institutional care to cases where it is unavoidable (*30*). The guidelines envisage sponsorship by private welfare services, churches or other religious communities, which guarantee permanence. In their absence, public community agencies may assume sponsorship, but private and public sponsorship should not be combined. The sponsoring agencies are to act as employers of the staff. The stations are to be licensed, strictly regionalized, and located within the area they serve. Some parts of the Republic have mobile care services similarly staffed, and domiciliary care associations frequently organize services to patients in their homes.

In France, the Ministry of Health and Social Security has considerable interest in promoting health centres and similar forms of organization, but implementation is difficult because doctors are free to practise how and where they like. Also, because the complex system of financing is basically one of reimbursing the patient, there is little leverage on the providers of services. In France, too, there are primary care institutions under public as well as private auspices. The general pattern is that general practitioners work singly or frequently in groups, while specialists work mostly singly, but some also in groups. Conditions for setting up medical organizations are laid down in Decree No. 77-636 of 14 June 1977. The patient is always to remain the responsibility

of the individual physician. There are limitations to the size of groups, smaller if all members practise the same specialty, larger for multi-specialty groups. Among the criteria for practice as a group are a common location and pooled office services.

Doctors may have joint arrangements for specific purposes such as emergency cover. Groups will have their own internal arrangements. Other doctors in the same locality may work out a rota, or there may be special agencies in the community to provide emergency services. Any of these arrangements may be linked to the public *Services d'Aide médicale urgente*, and there may be a common call number. Another structural form of primary care organization in France, as elsewhere, is the hospital outpatient clinic, which may be accessible directly by the patient or on referral by the general practitioner. Dispensaries deal with specific disease groups, aiming primarily at prevention, diagnosis and case finding. The preventive aspects are publicly financed. Diagnostic services and treatment are paid for from insurance or by the patient. There are statutory minimum standards for buildings and staffing, the latter determining the range of services provided.

About half of the 600 or so medical centres in France operate under miscellaneous auspices and about one sixth under the municipalities or social assistance agencies; some 80 centres are organized by mutual insurance carriers and the remainder by industrial establishments or the Red Cross. There are about 400 dental health centres in the country, also run by a variety of agencies. Examples of the various types of sponsorship are clinics operated for their members by the different mutual insurance funds, general multi-specialty and dental clinics under the auspices of the social security administration, health centres instituted by local councils, and those run by private non-profit organizations. As in the Federal Republic of Germany, French doctors in private practice form their own groups to suit their particular requirements and objectives within the general statutory guidelines described above. Both countries have institutions whose aim it is to coordinate the various agencies providing similar or related services under different auspices.

There are also national organizations that establish and maintain liaison between the public sector and private initiative in the health and welfare field. In France, this is the remit of the Union nationale interfédérale des Œuvres et Organismes privés sanitaires et sociaux with its regional and local branches. Its aim is not only to coordinate private organizations providing health and social services but also to bridge the gap between the private and the public sectors. This covers, on the one hand, non-profit and commercial organizations and, on the other, the public sector services and social security. Private agencies, for their part, are organized in France in the Union nationale des Associations familiales. In the Federal Republic of Germany a somewhat similar purpose to that of the French Union nationale interfédérale is served by the Deutscher Verein für öffentliche und private Fürsorge. It is mainly a social service body, bringing together representation from public

agencies and voluntary social welfare associations at all levels. The aim is to serve as a focal point for all activities in the social welfare field in the Federal Republic.

In the Swiss Canton of Vaud the Organisme médico-social vaudois in Lausanne has an administrative council with representation from the canton, the local authorities and the public, as well as private health and social services agencies. Individual stations are headed by a director assisted by a deputy director, and staffed by nurses and administrative personnel.

The government operated health sector in Greece provides health stations with about 6–10 attached beds for populations of about 5000. There are smaller units, "dispensary offices", for populations of about 2000.

In the Netherlands, as in other pluralistic systems, there is a range of structures for the provision of primary care. In 1977 about 70% of general practitioners still practised single-handed. The remaining 30% worked in 45 group practices and 66 health centres. In the latter, general practitioners work together with district or public health nurses, social workers and other health workers such as physiotherapists, midwives, dentists, dietitians and pharmacists (*31*). There has been a steep increase in the number of medical groups and health centres over the last decade. During the first half of that period it was the group practice type of organization that grew more rapidly, probably because independently practising doctors became aware of the advantages in grouping together. Later the number of health centres outstripped group practices, an indication perhaps of a greater impact of public policy regarding the organization of health care.

In the Republic of Ireland, the Department of Health has adopted a policy of making provision for health centres for as many as possible of the primary care needs in the health and personal social service fields. Plans would take into account the size and density of the population to be served, as well as the existence of alternative sources of care such as hospital outpatient clinics. The envisaged change is from the provision of general medical services by district medical officers employed on a part-time basis and working from health board dispensaries, to a system giving a choice of doctor to eligible persons and enabling them to seek care at doctors' own premises. Grants to doctors would act as incentives for them to provide their own premises. Health boards are also prepared to provide practice premises in new health centres for general practitioners who are members of a medical group. Premises are also provided to attract doctors to remote or thinly populated areas.

In summary, there is a trend in all the countries that still have a large private sector of medical practice to consolidate single-handed practices into some form of grouping. Government leverage varies considerably from country to country, as do legal provisions for the grouped or collective practice of medicine. Health centres, publicly sponsored and housing multidisciplinary teams, are gradually developing to cover defined areas or populations, and frequently coexist with

private practice. Half-way measures, such as the pooling among practices of laboratory services, have the advantage of rationalizing the use of expensive equipment and personnel, but they are also considered as stimulating excessive and indiscriminate use of sophisticated equipment (*32*). In some countries, insurance mechanisms are not geared to collective practices.

Another factor promoting effective coordination, despite the multiplicity of agencies involved, is the growing recognition that primary care must become more community oriented and avail itself of a variety of services. Independent individual practitioners would find it increasingly difficult to maintain communication with the many community agencies from whose services their patients might benefit. A possible solution to this problem is at least approached by the various forms of medicosocial station existing in several countries, where independent physicians can refer patients for nursing and social services. The "hospital-at-home" programmes serve a similar purpose. They resemble the North American home care plans, mostly administered by visiting nursing agencies, which maintain liaison with a great variety of community services. The extension of this model into a "community health service office", as illustrated in Fig. 2 and 3, could serve to facilitate multidisciplinary and multi-agency coordination where a multiplicity of agencies still exists (*33*).

European patterns in perspective

A working group, meeting in Moscow in 1973, concluded "that the proper functioning of a team is more important than the particular premises from which it operates" (*34*). Facilitating teamwork is indeed the chief *raison d'être* for the development of health centres. While some countries, such as the United Kingdom, reserve the term "health centre" for specific purpose-built or adapted physical facilities other countries, though preferring a single location, put more emphasis on a health centre concept implying effective coordination of the various services required. However, the working group confirmed that, other things being equal, "the effective functioning of a team is likely to be promoted if it operates from a common base and is supported by adequate facilities". The terminology for that type of facility varies and there is no clear-cut distinction between health centre, polyclinic, group practice in its various forms, dispensary, or health station. The term "dispensary" is also used to denote either a clinic providing specialized services or a basic primary care facility.

The working group also stressed the need for a health centre to be associated with a hospital, either by physical incorporation or by what the group described as a satellite relationship between one or more health centres and a hospital. Such a relationship is essential for referral for inpatient care, as well as for the availability of diagnostic equipment and specialist consultation. This sort of relationship is generally found in the European Region, although communications and exchange of

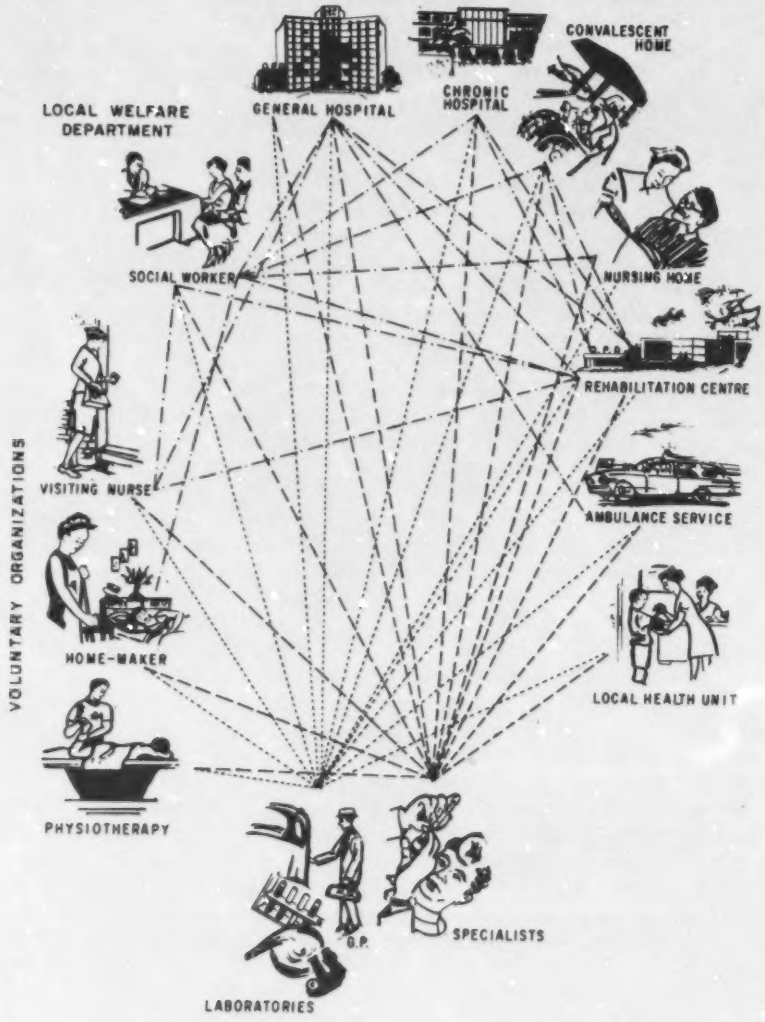
records are not always what they should be between the hospital and the primary level.

The dilemma in siting a health centre was observed by the working group, i.e. the need for a centre to be close to its clientele and, on the other hand, the trend towards concentrating services into a larger centralized unit that can be better provided with modern equipment and support services. This problem has been studied in Sweden and the United Kingdom, for instance, and it appears that after some initial resentment on the part of the population, better services in a somewhat more distant location are acceptable provided that transport is available, preferably as part of the service, and also provided that the larger centre can avoid being too impersonal. This will be partly a matter of the physical layout of the facility, such as waiting room arrangements and the availability of various amenities, but mainly it will be a matter of the spirit in which the primary care team functions. In this regard the WHO Regional Director for Europe, in his report to the Alma-Ata Conference in 1978, commented that a health centre can provide better services for the members of the community than fragmented health and welfare services. To overcome any feeling of impersonal service, the patient could be met by someone on the staff who would act as a kind of "patient advocate", who would listen sympathetically and advise the patient.

In the pluralistic health care systems in the Region, governments generally favour the development of health centre-like organizational forms, but these are slow to develop where the form of practice is left to the individual practitioner. However, a number of devices are being developed that aim at coordinating at least some of the health-related community services, such as nursing and social services, and making these readily available to practising physicians for their patients.

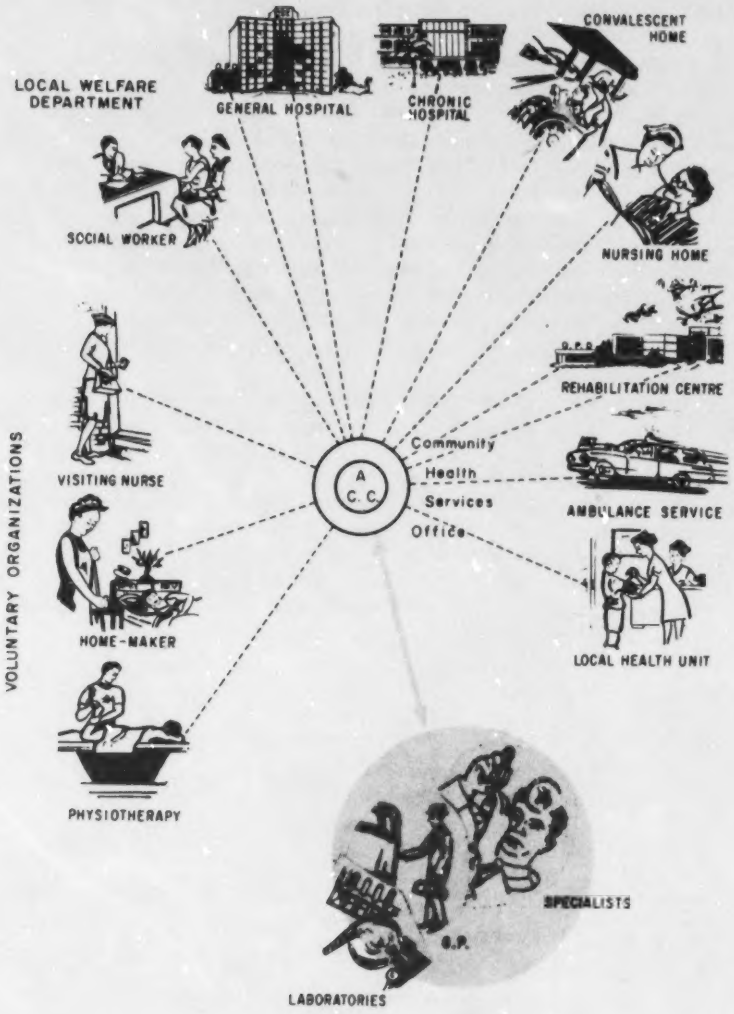
The capital cost of providing purpose-built premises has become a problem at a time of severe economic constraints. Apart from the expedient of straight cuts, the possibility of adapting existing buildings is being explored, as well as the provision of financial assistance to doctors who improve their own premises. Abel-Smith & Leiserson (*35*) aimed their comments mainly at the non-industrialized countries, but their observation regarding primary care facilities has equal meaning elsewhere. They refer to the use of local community action programmes for the building of the necessary premises. Apart from the savings, they observe, "the use of local voluntary labour in construction encourages local interest in the planned health services and participation in the activities promoted from the building after completion." The report of the Alma-Ata Conference (*36*) also mentions the adaptation of existing buildings or the sharing of premises as a cost-saving device and suggests that where a building has to be specially constructed "the community can often do this with their own labour and materials", thus retaining some interest in and responsibility for the facility "where they feel at home". The device of using voluntary labour is not unknown in the European Region. At one rural health centre in Hungary, for example, it

Fig. 2. Inter-agency lines of communication before . . . .



Shift of emphasis from hospital to community care and stress on outreach in primary care require the primary physician or team to maintain effective liaison with many community agencies, only some of which are shown here. The bewildering network of communications is difficult to maintain, particularly for the physician.

Fig. 3. . . . And after



Where there exists a multiplicity of agencies, many under different auspices, the function of maintaining the necessary communications could be assigned to one central agency to which the physician or members of his team could refer patients, just as they are now referred to a hospital that coordinates all available services within it.

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was reported that the use of voluntary labour saved about a quarter of the building cost. In some other countries, however, such a scheme may run foul of labour union policy. This, furthermore, is but one form of community participation that may affect the structure of a primary care facility, especially if a health centre is to be accepted as the centre of community leisure, education and recreation as well as care, a concept still rare in the Region (*37*) but not entirely unknown.

The adequate provision of primary care has become a new priority as emphasis in health care shifts from the hospital to the community outside. This is very much in evidence in the Region, and primary care is seen as the foundation for achieving health for all by the year 2000. In this context, WHO (*38*) warns that in the planning of [illegible] costs of maintenance as well as of construction must be borne in mind. The structure of primary health care organization may well constitute one of the areas where WHO, in pursuing its strategies for health for all, could provide Member States with alternative approaches to suit their particular requirements.

At present, patterns of management and administration of primary care facilities vary with the system in which they operate. Correspondingly, the proportion of the population covered by or having access to health centre-like facilities ranges from complete coverage in the socialist countries to partial coverage in other European countries where the health centre concept is still developing. In these countries coverage may be provided for the general population in local, usually rural, areas where centres exist, or centres may serve certain population groups such as employees, indigents, or selected categories of patient.

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8

Primary care and the community

There are several dimensions to community orientation by primary care organizations. One is part of the concept of primary health care as a medical function, which presupposes responsibility for the health care of a defined population including outreach, prevention and health education, aspects of which have been discussed earlier. Another is the role played by the providers of primary care in general in the life and development of the community served by a health care facility. It is the second aspect that will be emphasized here, although the two sides of the picture cannot be completely separated.

In describing, in the preceding chapter, the structure of primary care organizations, reference was made to the health centre concept formulated by the WHO Regional Director for Europe, i.e. the notion of a health centre as "the centre of community leisure enjoyment, education, and recreation, as well as care (including prevention, rehabilitation, etc.)" (*1*). The idea here is obviously not that a health centre should cater for all community needs in respect of leisure, education and recreation, but that the centre need not confine itself to the provision of clinical medical services but could show concern with the health related aspects of social wellbeing.

A prerequisite for developing and maintaining community concern is a defined community, preferably the general population of a discrete geographical or administrative area. In countries with pluralistic systems where, for the most part, practitioners operate independently in the private sector, community orientation will be rare not only because of the difficulty of knowing what constitutes the community, but also because health professionals are not prepared by their training to do anything beyond applying their medical knowledge and skills. It is the more remarkable that, despite these constraints, there are individual practitioners who attempt to practise not just care of illness but also care of health in the meaning of the WHO concept.

It should be remembered that the role of the traditional medical officer of health in applying public health measures has always been very much community oriented. Measures to protect the public from communicable diseases often affected community life very considerably,

as when John Snow removed the handle from the Broad Street pump in London or when Ibsen's Dr Stockmann became "an enemy of the people" because he saw the dangers of water pollution. Various forms of quarantine had to be observed by the community at large.

If the various preventive measures lead to the effective control of infectious diseases, the control of the major chronic diseases likewise will come about by prevention rather than merely treating the sick. Primary prevention, through the necessary intervention strategies against heart and other diseases, requires not only the individual to follow appropriate lifestyles but that the producers of certain consumer goods—the tobacco and alcohol industry, agriculture, bakeries and many others—change their products in such a way as to enable consumers to follow the precepts of health education. Necessary changes in this area may be attempted by legislation, if and when the community is ready to accept it, but primary health care will always have an important role to play in efforts to achieve compliance with preventive measures or the control of risk factors.

In those countries in the European Region that do not have a national health service, it is frequently the community that is instrumental in instituting primary care facilities, such as in some communes in France. National or regional governments may provide a public health service in otherwise deprived areas, as in Greece and Turkey, or establish health centres or clinics in deprived inner city districts where they are used primarily by the poorer sections of the community. The danger here is that health services provided especially for the poor may turn out to be poor health services, although this is by no means always the case. There are situations where the primary care facility as such is a creature of the community, or the community may be instrumental in establishing particular projects or services to be undertaken by a health centre or clinic.

In the United States, for instance, health centres in poor areas, particularly in the larger cities, were established in the 1960s as part of a broader programme to cope with the general problem of poverty. Health centres were established because something had to be done for people's health care if other programmes to alleviate poverty were to work. Community participation became an essential feature of those health centres, ranging from an advisory role to full control.

If the health institution is to play a part in the life of the community, beyond the provision of personal medical services, it follows that the community must have some liaison with the health facility. Health centres provided in pluralistic systems for special population groups or areas will be more likely than private practitioners to take on such functions as health education and prevention to compensate in some way for social deprivation. This applies to the Turkish *ocaks*, to commune-sponsored centres in French towns or general and dental clinics established by the social security administration, and to the *Sozialstationen* in the Federal Republic of Germany. Other countries in the Region with mixed systems have similar institutions under

government or private voluntary auspices aimed primarily, if not exclusively, at target groups among the general population. These, however, are programmes directed at alleviating the consequences of social deprivation, not at removing it. The latter, of course, requires political will and resources beyond those of primary health care but the health services can act as a catalyst, as indeed some medical officers have done in the past. It was the social motivation of individual physicians—Pearse in England, Silver in the United States and Kark in South Africa—that led to the establishment of the Peckham, Montefiore and Pholela centres, respectively, each with a somewhat different orientation.

Thus, in systems where the orientation and form of practice depend on the individual physician rather than national policy, there is no organizational infrastructure to facilitate liaison between a primary care facility and the community; where an effective relationship is established, it is due entirely to personal initiative and thereby limited in scope and content. Such outreach and concern with social factors as exist, therefore, are by and large confined to those members of the community who have sought care. In these situations personal attitudes on the part of both consumer and provider of services play a major role. An interesting insight into this relationship may be gained from observations in an area where personal trust and confidence matter a great deal, i.e. in matters relating to family planning. A study carried out in the United States on the use of family planning services by newly married women (*2*) compared the interaction between health worker and client in private practice and in a family planning clinic or hospital. It was found that in the clinic or hospital, it was more often the health worker who initiated the discussion, indicating greater reluctance to discuss very personal matters in an organized setting than in the doctor's private office. However, a family planning clinic may well arouse a different reaction than a physician's practice located in a health centre. Patients' attitudes to health centres will be referred to again later in regard to specific institutions in countries where this aspect has been studied.

As to the community orientation of the providers of services, especially the physicians, Andrija Štampar observed in 1928 that "physicians are too much engaged with the individual and too little with the community" (*3*). There is perhaps a trend towards a change in medical education away from the traditional, too individualistic ideology towards greater attention to the "global society" (*4*). However, the orientation varies among categories of physicians, and the public image of their orientation among different groups of the population. A study in the Yugoslav Socialist Republic of Croatia found, as may be expected, that general practitioners were more likely than specialists to be involved in the social problems of the community (*5*). This was true in both rural and urban areas. In the same setting, people's perceptions of the attitude of physicians towards community problems were that doctors were more positively oriented in rural than in urban communities. Community concern in that study included not only

matters directly affecting health, such as housing and social welfare, but also public administration generally, road building and economic development; in short, all matters affecting the life of the community (*6*). This may perhaps be an indication that we are moving towards expressing in concrete and operational terms (and, it is to be hoped, eventually implementing) the philosophy held by Sigerist and others in the past, of medicine as a social science (*7*). William Osler put it directly to his students in a session on their duty to their college, themselves and the public (*8*):

> The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders, but with the exercise of an influence of the strong upon the weak, of the righteous upon the wicked, the wise upon the foolish. . . . Fully one-third of the work you do will be entered in other books than yours.

All this does not mean that the physician or any other health professional has to become an active politician or proficient in the construction of housing or sewers. But he should be aware of the impact of the broader social and physical environment on health, and exercise his influence accordingly. Like those in other professions or trades, he should not be satisfied with his technical expertise but be aware also of its purpose and consequences. It is incumbent upon the educational system to foster that broader awareness of the individual's social function by what may be termed the educational element to complement vocational training. In medical curricula there is increasing emphasis on the social aspects of medicine. It is refreshing to see, for instance, that medical students in Leipzig, in the course of their industrial hygiene practical, concern themselves not only with hygiene within industrial establishments but also with any nuisance to the neighbourhood created by industry or the cost of readapting industrial processes and establishments, thus contributing to the city's reconstruction (*9*).

While community orientation of the individual practitioner is essential, it can be put into practice on a national scale only if supported by national policy and an administrative framework facilitating the necessary liaison between health services and other community activities. The extent of individual motivation and of general local and national policy backing will determine the effectiveness of the local health services in advancing "community wellbeing" – physical, mental and social. This relates to "the social situations affecting the individual's health and the more general social problems affecting the community's overall standard of health" (*10*).

The occupational health services in the socialist countries offer an example of institutions attending to both the individual employee's health care needs and the creation of a healthy working environment. There are, however, so many areas where the primary health services could make an impact, and so many ways in which other sectors could be influenced, that it is impossible to provide a complete picture of the

situation in the European Region, except in a negative way by saying that much remains to be done in all European health care systems before the objectives of Alma-Ata are implemented. In general it can be assumed that closer liaison and greater involvement in all community affairs will be found where primary health care is locally financed, and therefore has its priorities determined in the context of overall local planning.

When discussing community involvement, the question always arises of who speaks for the community. Two basic approaches can be distinguished here: one whereby the elected representatives in local government assume some sort of responsibility for the primary care services, possibly through a health committee; and another whereby community representatives are elected or appointed to deal specifically with matters pertaining to primary care.

The socialist countries of eastern Europe

In the socialist countries health services are part of the nation's centrally planned economic, political and service activities. It follows that the hierarchical organization of the health services at all levels—local, regional and national—reflects the corresponding political structure. For the primary care facility, which is strictly regionalized and serves a defined area, this means that it is subject to local planning and operation within the framework of general civic and economic activities, thus providing a ready made structure for a mutual relationship.

The health commissions or committees have "people's deputies" as members (*11*). In the USSR permanent health commissions are composed of members of the Supreme Soviets of the Union Republics and the local Soviets of Working People's Deputies. These commissions monitor the activities of the health establishments under their jurisdiction, and are involved in preparing the budget and in planning services. Among their functions is the soliciting of public participation in large-scale measures to improve sanitary conditions in their respective communities. This is reinforced by Councils of Voluntary Public Service, whose members include representatives of the trade union movement, industrial establishments, collective farms and the general public. Prominent among voluntary agencies supporting the health services are the Red Cross and Red Crescent. The anniversary of the day on which the People's Commissariat of Health was established, 11 June, is set aside as Health Day, on which the achievements of the health services are reviewed and public interest in health promotion is stimulated (*12*). The dispensaries, through their programmes aimed at health maintenance and prevention of illness, exemplify the commitment of the health services to the community (*13*). Where outreach activities comprise elements of primary prevention, they inevitably affect the lifestyles of individuals and the community. This is bound to meet some initial resistance, particularly from those not actually ill, and it is here that volunteer effort complements the efforts of the *ucastok* doctor and

nurse. To this end, a large body of volunteers is recruited—one for approximately every 6–10 households—to maintain liaison between the community and the health service. This is seen as essential for the implementation of many of the health measures (*14*).

Other socialist countries conceive of the community–primary care relationship in a similar way to the USSR. In Bulgaria, the Ministry of Public Health sees it as a function of health education to bring about the population's participation in the solution of health problems. Czechoslovakia emphasizes the role of primary care in caring for the family and dealing with social problems. Community relations are seen to be facilitated by the organization of primary care on a territorial basis, whereby health service catchment areas are generally identical with the political–geographical division of the country. This implies that there is no free choice of physician, although within a polyclinic the patient can be referred on request to another community physician.

The German Democratic Republic ascertained the popular preferences for various forms of primary care organization by sociological investigations. Disadvantages of individual surgeries had been recognized and, as in other countries, efforts were made to consolidate these practices into larger units. But in doing so, the demands of the population were taken into account; surveys showed that 44.7% of the population preferred polyclinics, 31.2% stated that it made no difference to them and it all depended on the doctor, and 24.1% preferred care at an individual surgery. The programme of the Socialist Unity Party of 1976, dealing with the control of the principal health problems, stated that research into their cause together with the protection of the environment constitute a medical contribution to improving the working and living conditions of the community. As one author put it, man is the centre of the socialist society which has as its ultimate objective the maintenance and promotion of man's health, productive capacity and enjoyment of life (*15*).

The importance of strict regionalization is also emphasized in Romania; it is seen as ensuring for a clearly defined population the effective coordination of all preventive, curative and rehabilitative activities. The same principle of providing a comprehensive service to a clearly defined community is behind the integration of health services in the city of Budapest (*16*).

Among the checks and balances built into the Yugoslav system of autonomous health institutions is the "social agreement" between those institutions and the community they serve. For the health institutions, these agreements ensure the interest and broad support of the community, while the community is assured of primary care services geared to its needs (*17*). Self-help clubs of patients suffering from chronic conditions or at risk of contracting them are becoming increasingly prevalent in Yugoslavia, as elsewhere. Functioning, on the one hand, under the sponsorship and supervision of the health service and, on the other, involved in the daily lives of people, the clubs

constitute a further link between the primary care facility and the community (*18*).

In the socialist countries, the dual function of occupational health services—the provision of personal health care to employees as well as attention to the working environment—is an illustration of close interaction between the medical services and the workplace component of community life.

Other European countries with a national health service

The kind of "social agreement" by which the primary care facility is integrated into general community planning—as described above in the Yugoslav system—creates a relationship of some similarity with the Scandinavian system and its traditional local financial commitment for the provision of health services. Hence primary care services in the Nordic countries emerge very much as creatures of the local administration in contrast, for example, to the National Health Service in the United Kingdom, which is an agency of the central government and thus needs special organizational arrangements to coordinate the peripheral health services with the community.

The Finnish Public Health Act of 1972 confirms the responsibility of the local authority (commune) for public health work, albeit within the framework of national health policy implemented by the National Board of Health. The local health boards consist of members appointed by the local council or, in the case of communal federations, by their federal councils. The local boards are entitled to requisition information "from governmental, parochial and communal authorities and from all those engaged in public health work". This right is limited only by the secrecy provisions relating to such information. Thus while the local health services operate within the directives of the National Board of Health the local health boards, appointed by the local council of elected representatives, also have a direct channel to the National Board, as well as the provincial boards, to which they are required to submit annual reports. The local board of health prepares annually a five-year plan for the public health work in the community, a plan which has to be approved by the local council and eventually confirmed by the National Board of Health. This indicates the close connection between the local health services and the local elected representatives. Because of the local board's direct responsibility for the local health services, it is the board that employs the health centre staff. Thus the system operates very much under democratic control, whereby community involvement and participation play a vital role (*19*).

Patients generally have a choice of health centre doctors, and they can seek care in the private sector where this exists. In Iceland any citizen can seek the service of any health centre that is the most convenient at the time. This differs from the situation in the United Kingdom where National Health Service patients must be on the list of

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the doctor consulted, although they can transfer to another doctor's list.

Sweden has been developing a variety of health centre models, with different forms and degrees of community involvement. In all cases, of course, the foundation for such involvement is to be found in the high degree of local responsibility for health services that is characteristic of the Nordic countries. Research by academic and government bodies, aimed at monitoring and evaluating the performance of health centres, has been concerned with various factors determining the relationship between a health centre and the community it serves. The notion of what constitutes that community is necessarily a flexible one. Since the social services, an integral part of health centres, are the administrative and financial responsibility of the local commune, collaboration must be established between it and the county administration responsible for the health services. Some of the health centres outside the larger cities, such as that in Tierp, resulted from the consolidation of several rural practices, bringing about a change in the population covered. This necessitated new relationships between levels of government so that they could parallel the responsibility of the primary care service, both health and social. The implications have been the subject of study in the case of the Tierp Centre (*20*) and much of the experience gained there will be relevant in similar situations elsewhere. To begin with, it was to be determined whether planning for primary care services could be based on qualitative as well as quantitative population data—whether in addition to population size, travel distance, etc. social factors such as living standards could also be determined and taken into account. Further, whereas in the socialist countries the occupational health services are integrated into the primary care sector, Tierp aimed at another sector of community life: school health. In this regard it should be noted that what is referred to as "student care" provided by the education authorities covers not only medical care but also social needs, career advice and recreational activities, all of which are coordinated through the presence of the chief education officer on the centre's coordinating group. Besides the National Board of Health and Welfare and academic and government research units, both the local municipality and the competent county council were involved in the development of the centre from the very beginning. Three representatives from the former and two from the latter served on the collaboration committee responsible for the management and coordination of the project work.

The total area covered by the Tierp centre was divided into four sectors, each with a population of about 4000–6000, to be served by an area group with a joint social–medical team. Among the tasks of these groups were (besides the provision of medical and personal social services) maintaining liaison with formal and informal population groups to ascertain attitudes towards the services, reporting local opinions, and submitting suggestions to the appropriate municipal and county bodies. The social–medical team could call in representatives of other bodies as required. The list of items dealt with in the very early

stages of the centre's operation included pensioner service requirements, rural postal service needs, recreational activities, parent training, play facilities and equipment, pre-school planning, and unemployment among young people. Contacts included those with the pensioners' association, the recreation board, teachers, the play environment council, trade unions, the labour exchange and the social insurance office.

It is clear that this catalogue of community problems and the range of community agencies involved reflect areas of community concern with a clear health component, while outside the field of medical care proper. The importance of mutual awareness of the interrelationships and will for joint action is well illustrated by the situation in Tierp.

Direct input into the health services by the local administration is lacking in the United Kingdom. Here the National Health Service as a whole is administered and financed centrally. The regional, area and local health authorities operate within guidelines filtered down from the central ministry, but it is the purpose of these lower management tiers to adapt the guidelines, where possible, to local needs based on their knowledge of local conditions. It is largely the function of the community physicians (who are on the staff of the authorities and who have no clinical functions) to supply this knowledge. Their role is an adaptation of that of the traditional medical officer of health, and lies mainly in the field of planning and management. In order to facilitate community input, the reorganization of the health service in 1974 created "community health councils" whose function, however, is to advise the health authority concerned. These community health councils may be abolished again in the course of a recent reorganization, which has done away with the area tier of the health service. The rationale for this is to simplify the administration. It is argued that, if there is to be a fully fledged health authority at the lowest level, i.e. the district, that authority will be close enough to the community to make a separate body such as the community council redundant.

That is the situation in the United Kingdom with regard to the health service in general. Primary care, in particular, has little concern for the affairs of the community at large. Where such concern does exist or where it is felt that the community should participate actively in the management of primary care, this comes mostly from personal motivation and interest on the part of health professionals or from active community groups, or both. It is important here to bear in mind the very heterogeneous forms in which primary care is practised in the United Kingdom, ranging from the solo practitioner, through the partnership or group, to the formal health centre. The first two may or may not have nurses and social workers, but the community served by a general practitioner consists of some 2500 people who have chosen and been accepted to be on his list. It would be conceivable for the individual practitioner to display greater interest in the health rather than just the sickness of these people but even this is very rare, if it can be said to exist at all. The National Health Service still remains very much a sickness service, despite policy statements in favour of health

maintenance and prevention. But not being responsible for the population of a defined area, the general practitioner could not be expected to take an active interest in community affairs, apart of course, from his personal interest in civic affairs. Nor could the community be expected to become involved in the running of the various separate practices in its midst.

There have been suggestions from time to time that the responsibility for the health services be transferred to the local authorities, but this aroused fears about the identity of the health service. It would also mean a major restructuring of the financial basis and it would have to take into account the secondary and tertiary health facilities lying beyond purely local concern. As far as primary care is concerned, therefore, it operates within the community but as part of a national system like the postal services or railways. It lacks the affinity to general community affairs that now exists in areas subject to community policy, such as the social services, housing and education.

The United Kingdom thus lacks the concern of the community for health, and of the health services for general community affairs, that exists in the Nordic countries. However, particularly in primary care, there are scattered attempts here and there to get, if not the community as such, at least groups of service users involved in the running of the health services. This sort of arrangement differs again from consumer control in North America, where health facilities may be sponsored by and operate under the auspices of certain organizations such as trade unions or the anti-poverty programme of the US Office of Economic Opportunity, which may not only decide the policy of the sponsored primary care facility but also take a hand in aspects of its day-to-day operation.

The community health councils, mentioned earlier, are intended primarily to represent the interests of the public to the health authority. They are not meant to participate in the operation of individual practices or other primary care institutions. In the United Kingdom, as in all other countries of the European Region, the participation of voluntary organizations in the provision of health services forms an important but supplementary part of community input, i.e. offering services not otherwise provided by the national service. More directly relevant to the present discussions is the development in the United Kingdom of patient committees in group practices or health centres. A Royal Commission reviewing the National Health Service (*21*) wanted to see these committees encouraged and recommended that "financial support should be given to encourage the setting up of patient committees in general practice". The Commission gained the impression that the development of these committees had been spontaneous, usually resulting from the desire of one or two general practitioners to improve their service in line with suggestions from patients. Since these committees are the result of local initiative and individual motivation, they vary in their function and composition and in the way they operate. They provide for informal meetings between health professionals and

patients and they can be effective vehicles for health education, health maintenance and prevention activities, as well as for the formation of self-help groups for the control of certain diseases or risk factors.

In England and Wales alone the number of patient committees, or "patient participation groups" as they are also called, has risen to about 30, and they have formed a national association. The development is favoured by the Royal College of General Practitioners which, at a seminar held on that topic, pointed out that these groups or committees always have an important role to play, but particularly so in times of financial constraints when priorities are questioned and re-ordered (*22*). The increasing attention paid to this form of participation is reflected in an article on the subject in a recent issue of a quarterly review "for the medical profession" issued by the Department of Health and Social Security (*23*). It was a health centre in Scotland, in Aberdare, whose pioneering contributed much to the interest in patient participation.

Other approaches to more immediate community involvement include the "inner city partnership scheme", resembling somewhat the anti-poverty programme in the United States, whereby central resources are made available to local statutory bodies for use in defined areas, such as inner cities. Also related to inner city problems is that of attracting personnel to practise there; special allowances are the usual incentive and one suggestion has been to scale such allowances according to the number of "social deprivation factors" present in the particular area. This opinion was also expressed at a meeting of the General Medical Services Committee on the issue of providing primary health services in under-doctored areas. At present, an area is identified as under-doctored, or "designated", if the general practitioners' lists exceed a certain number of patients. Some members of the Committee felt, however, that the social disability of an area should also be taken into account. In addition to monetary inducements, consideration should be given to the provision of practice and living accommodation as well as of extra nursing and other field staff (*24*). Among inner city problems in the United Kingdom is the presence of large numbers of immigrants with their problems of acculturation and language difficulties. Health authorities, in their efforts to provide effective services and health education to these groups, have been collaborating closely with their community organizations. An interesting new effort to attract doctors to hitherto under-doctored areas comes from the private sector: one of the large department stores offers to let space at a reduced rate to doctors in inner city areas, an offer extended also to other professions.

The limited input of community or consumer into the working of primary care must be seen in the context of the numerous other provisions for public participation in decision-making in the National Health Service. First of all, it is the elected representatives in Parliament who decide on policy and the statutory framework, and the secretary of state is accountable to Parliament for the service. Then there is lay representation on the authorities at each level of the system, and there are the community health councils. For specific complaints there is an

ombudsman in the person of the "health service commissioner". Also, as described earlier, the erection of a new health centre is usually preceded by community surveys and local statutory bodies are inevitably involved in the planning of the facility.

Thus, in a system such as the British, with a rather flexible type of primary care organization, what is lacking in structures for community involvement may be compensated for by the variety of approaches and solutions attempted.

Pluralistic health care systems

If under the British system there is only limited leverage to influence the way general practitioners organize their practice, such leverage is practically nonexistent in countries without a national health service. The Belgian Ministry of Public Health and Family Affairs has said that none of the practices and centres in that country assumes responsibility for a defined population, and this holds true for other countries with pluralistically managed health services. Centres consider themselves responsible only for patients who consult them. Some require nominal contributions to establish membership, and this establishes some mutual commitment similar to that of the patient list of the British practitioners or the *mutuelles* in France.

Lack of a common policy and organizational structure in these countries does not mean, however, that ideas of establishing closer ties with patients or the community at large are unknown or go completely unheeded. Even the narrow medical model of services for the sick increasingly means going beyond the traditional ways of considering the patient only when he consults the doctor. The monitoring of risk groups such as those with hypertension or intervention strategies for coronary heart disease are more and more becoming part of medical care. The extent to which they are implemented by an individual practitioner or a group depends on their orientation, motivation and resources. The Belgian Ministry notes that where health centres of some form exist, there is often an awareness of the need to secure participation of the population in maintaining or regaining their health, but under the prevailing circumstances it is seen as one of the most difficult objectives to achieve. Nevertheless, some centres do obtain patient or community participation, for instance through patient committees, periodic meetings, or other forms of advisory input into the centre's operation. Some publish bulletins with health educational material or encourage collective preventive action, but actual participation in the management of a centre is very rare.

Some of the *mutuelles* in France provide for participation of the covered population. Health and social service centres such as the *Sozialstationen* in the Federal Republic of Germany operate directly under the auspices of voluntary secular or religious organizations.

Where, as in some communities in France, health centres are established under the local council, the council or its health committee

exercises control over the centre's operation. The extent of control varies and in some cases manifests itself only in the control of the budget.

The general picture in those European countries where primary care rests largely in the private sector remains one of traditional limitation to the conventional medical model and, for most primary care practice, there is no commitment to a defined population. In other words, practising in a community is not synonymous with service to the community.

Conclusions

The ultimate measure of how well a primary care system is attuned to the community would be the extent to which it fills the health needs of that community. This raises a number of difficult questions which so far have been avoided in this discussion. One is the concept of what constitutes the community and who speaks for it. Another is the meaning of health – the medical or the social model, or a combination of both. Consumer satisfaction is but one small aspect of it. Consumer reaction to health centre services in particular has been studied in several European countries, especially following the establishment of new centres. Some very specific areas of dissatisfaction have been identified here and there: impersonal service and environment, lack (real or suspected) of confidentiality, geographical remoteness, difficulty of access for elderly or handicapped patients, etc. All these are not necessarily inherent in the system, but they do indicate where consumer input could help to improve the services and make them more acceptable.

In presenting the regional point of view to the Alma-Ata Conference, the WHO Regional Director for Europe commented on the problem of "community nonparticipation in medical care" and the still largely prevailing authority of the physician, which is usually respected by the community. He added: "The extent of community participation in PHC undoubtedly reflects community participation in other major aspects of communal life. Some European populations are more participant than others" (*1*). As will be seen from the foregoing discussion, where participation exists it varies greatly in its form, scope and purpose. Representation of the public may take the form of elected representatives at the national level determining general policy and laying the statutory framework for the health services. Also concerned with the general organization rather than the performance of individual practices or institutions are health committees of regional and local government, or specially appointed health authorities as, for instance, in the United Kingdom. At the service level, on the other hand, there are the various forms of patient committee. The function of the latter in one of the pioneering health centres in the United Kingdom—the Aberdare health centre in Scotland—has been described as "to participate with the health team in running the primary care unit", emphasizing thereby that there is no suggestion of confrontation, as shown by the fact that during the

initial three-year period of the committee's existence there have been only three complaints. On the other hand, the centre could boast of having secured broader community support by instituting an "age action committee" which secured the cooperation of local milkmen, postmen and newsboys in programmes to assist the elderly (*25*).

The emphasis on collaboration rather than confrontation has also been evident on the North American continent, where in the 1960s consumerism developed largely as a force to counter unresponsive bureaucracy in business and government. In commenting on consumer representation in health centres established by the Office of Economic Opportunity in the United States, the President is quoted as saying (*26*):

> The time has come to bury forever the myth that furthering the interest of the consumer must be at the expense of the producer. There is, I am convinced, a common interest between Americans in their capacity as producers and in their capacity as consumers. This mutuality must be emphasized.

But there are, no doubt, consumer groups and committees who see their role primarily, if not entirely, as watchdogs, the result of mistrust in an establishment that previously ignored their views. There are the two schools of thought regarding the stance to be taken up by consumer representatives (*27*):

> One school of thought has attempted to gather community residents together over issues of conflict and confrontation. In such programs, the issues may be real or imagined, but in either case they are used to arouse community interest, if not indignation. The principal work of such organisation is to confront the power structure external to the community and to protest inequities.
>
> The other school—call it the service orientation—tries to identify real needs in communities and, together with the community residents, organise into a meaningful structure which meets their basic needs. The difference in this theory of community organisation is that, if successful, it will bring antipolitical groups together in a situation where compromise—political or otherwise—will help both parties (sides) to achieve what they want.

As a Canadian proposal for the establishment of community health centres in that country describes it, "the community health centre can only be effective if it is a mutually acceptable partnership of the members of the community and the members of the health care team" (*28*). This kind of partnership can readily develop where the local community is largely responsible, financially and administratively, for its primary health care. It will require a special effort, however, to develop the desirable partnership where the primary care institutions are part of a "power structure external to the community". In the pluralistic systems of the European Region, as in Australia, Canada and the United States, health centres, clinics or group practices come into being under a wide variety of auspices and each has to identify its own community or client group. A health centre in a small rural community in Australia, established under the Commonwealth's community health

programme at the urging of the local community, ascribes its success to the cooperation and goodwill of the entire local community. Community organizations help to raise money for the centre and participate in prevention programmes. A hall used by the centre for day care is also made available for meetings of local organizations. This mutual interdependence has resulted in the centre becoming more than just a centre for health care: it has become "an integrating factor, a symbol of co-operation and goodwill for the entire district" (*29*).

Health education, intervention strategies, screening programmes, and other projects requiring active participation not only of patients but of the general population depend on wholehearted support by the community at large. This includes epidemiological and other studies aimed at determining health needs. The Austrian Federal Institute of Health has studied popular reaction to such programmes, which constitute "a new dimension, complementary to other fields of medicine, in caring for the health of populations", where a positive orientation of the community at large is essential. This orientation must be achieved by effective health education programmes, since it is often difficult for healthy people to see the connection between preventive measures and health risks (*30*). An illustration of this sort of collaboration is provided by the North Karelia project aimed at controlling coronary heart disease in the community. A more limited project in the United States, concerned with adequate nutrition for pregnant and postpartum women, nursing mothers and young children, established the need for close integration of the government sponsored food programme with the health services; physicians, especially, should look upon the provision of foods and counselling "as a supplement to medical care to improve and maintain the health of low income, high risk mothers and small children" (*31*).

In discussing, in an earlier part of this book, the process of planning for a new health centre, it was said that the watchword was consultation, and this includes the prospective users of the new facility. A Finnish report refers to the "adopters", i.e. the representatives of the main users, including communal health politicians and such organized pressure groups as trade unions, medical associations, nurses' federations, hospital leagues and various communal organizations. The personnel of the centre, while not involved in the decision-making process, do have primary responsibility in the planning (*32*).

A variety of arrangements whereby primary health care and the community it serves relate to one another has been described above. The relationships range from the minimal and almost nonexistant to a mutally beneficial and effective symbiosis that can manifest itself in two ways: the community, however defined, supporting the primary care team, and the primary care team extending its activities beyond the purely medical into other areas of community concern. Ultimately one would wish to see optimal development of both these relationships. With a few notable exceptions, primary care in the European Region is still some way from the ideal. However, primary care in Europe shares these

problems with the health care and social systems in other parts of the world and it is of interest, therefore, to glance at corresponding developments elsewhere.

There are signs that even in the absence of any encouragement from the prevailing health care system, the need for the primary care facility to reach out into the community is becoming recognized. That consumer partnerships of some sort spring up spontaneously here and there, indicates that either consumers or providers feel a need for such a relationship or at least see in it certain advantages for making the service more effective. As to the community supporting the primary care team, the Declaration of Alma-Ata asserts in article IV people's right as well as duty to participate individually and collectively in the planning and implementation of their health care. In article VII the Declaration makes it clear that primary health care, for its part, involves more than just the health sector proper, i.e. "all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors", and it "demands the coordinated efforts of all those sectors" (*33*). If the reference to some of these sectors may appear far fetched in the European context, their relevance becomes clear when one considers the ramifications of intervention strategies against some chronic and degenerative diseases and protection of the environment, where modifications in broad areas of industry and other activities will be required.

The Regional Director for Europe has presented a timely and accurate review of the present state of primary care in the Region and of its future tasks. His colleague in the South-East Asia Region has stressed the importance of reaching the community through health education, if health for all is to be achieved by the year 2000 (*34*). That primary care constitutes the key element in future health care systems, and that health is an integral part of socioeconomic development, had been accepted earlier by the Organisation for Economic Co-operation and Development in a report which also stated that health should be promoted largely by "providing citizens with the knowledge and the means to achieve greater levels of physical, mental and social effectiveness, helping them to modify their life styles—habits, exercise patterns, diets and guidance of alcohol, tobacco and drugs—in ways conducive to improve health" (*35*). Prevention and intervention in the development of disease or risk factors can be carried out on the individual patient, but such intervention is more likely to succeed if the community as a whole is ready for it, partly because of the moral support thus given to the individual but partly also because the necessary conditions must be created.

The primary care service, for its part, must keep abreast of changing health and illness behaviour in the community, as it must keep up with changing epidemiological patterns generally. Part of this is the changing composition of the population, changing rates and types of industrialization, and temporary demographic changes such as an influx of

immigrants or seasonal population fluctuations due to tourism. Immigrants may present special problems because of unusual disease patterns, but also because of problems of acculturation. Examples are the guest workers in central European countries and commonwealth immigrants in the United Kingdom.

Implicit in all this are pressures on the health professionals to act beyond what they have been trained for. But it should be noted that this is not peculiar to the health field; it applies to all sciences and all occupations. As one American scientist put it, "as to the scientific community, it has considered its primary role as one of acquiring and extending knowledge, leaving to others the roles both of educating the public about social implications of science and exercising responsibility over ways and means for adapting and controlling natural forces" (*36*). He continues by asking for that "kaleidoscopic blend of technical with social knowledge". This does not mean that the health professional has to become a renaissance figure, skilled in all branches of the human experience, but scientific knowledge and technical skill acquired by training should be complemented by education to create awareness of the social implications. There will always be decisions that should be left to the professional because they require the kind of knowledge, skill or experience acquired through training and which the layman does not have.

That the present lack of community involvement in many primary care systems is not confined to Europe is exemplified by a report on rural health centres in Saudi Arabia. The shortcomings noted there are equally prevalent in the European Region and elsewhere. They are ascribed partly to the hospital-based training of doctors, lack of qualified administrative personnel, and lack of community participation (*37*).

What has been said about teamwork and team relations applies also between the health professional and the patient or community; good relationships must be based on mutual respect and awareness of each other's contributions to a common goal. This is probably what is meant in a discussion of the role of the health sector in a socialist society (*38*), i.e. that the doctor in a socialist state, in this case the German Democratic Republic, is the expert called upon by society to maintain the health of the people. Other experts are trained in other disciplines, but all for the service to the community or society of which we are part.

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9

Financing

In general, organized primary care institutions in the countries of the European Region are financed on the same principles as solo practitioners, and primary care as a whole is subject to the financing policy that applies to all personal health services. In both respects, however, there are exceptions. In some of the countries with pluralistic systems, health centres may be operated under public or quasi-public auspices whereas other general practitioners, solo or in groups, are in the private sector. Also, there may be predominantly public or private non-profit ownership of hospitals, whereas ambulatory care is provided by private, independent practitioners. Discussion of all these aspects of financing policies and methods would go beyond the scope of this chapter which, therefore, will be confined to describing financing mechanisms mentioned as significant by either individual primary care institutions or the ministries concerned.

The emphasis will be on the methods of financing rather than on costs and amounts, since the latter would have little meaning in a cross-national review without establishing comparability and equivalence. Important distinctions are found in some countries between capital and revenue financing, as well as between the way a primary care facility receives its revenues and the method by which it remunerates its personnel. For example, patients or insurance carriers may pay on a fee-for-service basis, while doctors and other staff receive fixed salaries; alternatively, patients may pay fixed premiums but medical staff may be remunerated for each item of service.

Such variations reflect the respective roles of the public and the private sectors where both coexist; they are affected by priorities among the primary and other levels of care and, in the public sector, they will be determined by the degree of centralization or decentralization and the extent of local responsibility for the provision of primary health care. In reviewing the primary care situation in Europe in the context of the Alma-Ata Conference, the WHO Regional Director for Europe found it important to note "that the ideal of PHC as an integral part of the wider health care system can be effectively ended if health personnel are paid independently of that system. At the same time, much cooperation

is possible, and several countries have achieved a high degree of integration in spite of their *laissez-faire* payment systems" (*1*). An illustration of an attempt to achieve equity, if not equality, in remunerating the various members of the primary care team is the change made in Finland from item-of-service to salary payment for health centre doctors when the new Public Health Act of 1972 was implemented. There were several reasons for that change, but among them was the consideration that all members of the team should be paid on the same basis.

New approaches to primary care in the aftermath of Alma-Ata, and in the light of the re-ordering of priorities as a means of cost containment, inevitably have implications also for the financing of primary care services. Since the trend is towards a strengthening of this sector of the health services, the objective can be achieved only by organizing primary care resources sufficiently rationally so that multiple resources can be used in an optimal way. In those countries of the Region where the health centre concept, the idea of a multidisciplinary team, and a policy of outreach are as yet little developed, the typical hospital has about 25 other personnel per physician (about 15 if housekeeping and other ancillary staff are excluded), whereas there are only one or two others per primary care physician. There is good reason, of course, for some of this apparent imbalance: the hospital needs housekeeping staff and technical personnel to operate its sophisticated equipment, all of which accounts for a corresponding demand on administrative resources. However, with rising expectations of the functions of primary care and care in the community—an unfortunate term because it leaves the impression of the hospital being something apart from the community—we must expect an expansion of the team to provide the required outreach, to handle more diagnostic and treatment equipment at the primary level, and to make more of the remedial services available on an ambulatory or domiciliary basis. Where beds are attached to a health centre, they have to be staffed. Institutions such as day care (including day surgery) and hospital home care will tend to blur the dividing lines between primary and other levels of care, and make the hospital more clearly part of the community. The resulting shifts in the financing of the health services are strengthening the trend away from the solo general practice to the various forms of organized health care facility that have emerged in the European Region to enable primary care to perform its new functions and to meet the new demands made on it.

On the other hand, it may be the system of financing prevailing in a country that presents an obstacle to the development of new organizational forms of primary care. This is the case in countries that have a system of health insurance rather than a national health service and where insurance carriers, owing either to legal restrictions or to established practice, can have accounts only with individual practitioners and not with groups, centres or clinics. This used to be the case, for instance, in the Federal Republic of Germany.

A report prepared for the Council of Europe (*2*) on the organization of medical practice in Europe distinguishes two broad types of such organization: (*a*) medical partnerships with doctors practising independently or in a group, and owning their own equipment; and (*b*) practices where equipment and premises may belong to a public body or a private institution (usually a health insurance fund) which places them at the disposal of the team practising in those premises. A number of financial arrangements are possible. Doctors may pay rent to the owners of the premises and practise independently as described under (*a*) above. Alternatively, the doctors may become agents of the owner organization to which they will be administratively subordinate; in this case the owner (which may be a public body such as a municipality, or a semi-public body such as an insurance fund or similar) will retain the fees received and pay practitioners on the basis of services rendered. As a third alternative, doctors and other staff may be employed by the owner and receive a fixed income similar to the way in which hospital doctors are remunerated.

The method of financing can substantially influence the cost of primary care services. Because of the labour intensity of the services, implicit or explicit incentives and disincentives will affect the cost of operation. Maximal use of lesser trained and lower paid personnel will reduce the payroll, which normally constitutes about three quarters or more of the operating cost of a health centre (*3*). In comprehensive prepaid group practice plans in the United States, it has been demonstrated that certain pay structures with built-in incentives are associated with less use of hospital inpatient services and a lowering of the overall costs of health services.

These are matters coming under increasing scrutiny by systems analysis, operational research and modelling in health services management in most countries of the Region, regardless of the nature of the health care system. The application of these methods, however, is still fragmentary and generally too limited in scope to have a decisive effect on decision-making and resource allocation (*4*).

The methods of remunerating health service personnel, which are thought to affect the use and cost of health services, vary considerably among the countries of the European Region; in many cases, especially in countries with a pluralistic system, they also vary among the different categories of personnel. Whereas nurses, therapists, technicians and non-medical personnel are paid fixed salaries, doctors, dentists and pharmacists frequently receive a fee for each item of service, a capitation fee, or combinations of these. And, for these latter categories, the method of remuneration may also vary between those working in the hospital and those outside. The various methods as well as their effects (real or imputed) on the services provided have been extensively studied (*5*, *6*). Each method has certain advantages and disadvantages, but there is no ready answer as to why certain groups of personnel, and the most highly trained at that, should require special stimulants of a monetary nature to exercise their profession in a manner optimal for their patients

and for the use of available resources. It should be recognized, however, that item-of-service billing by physicians provides useful statistical data not otherwise available for primary care services. Also, negotiating fee schedules for insurance payments makes it possible to build in incentives for certain procedures and disincentives for others, thus encouraging, for instance, preventive rather than curative procedures' or discouraging unnecessary use of expensive equipment and materials.

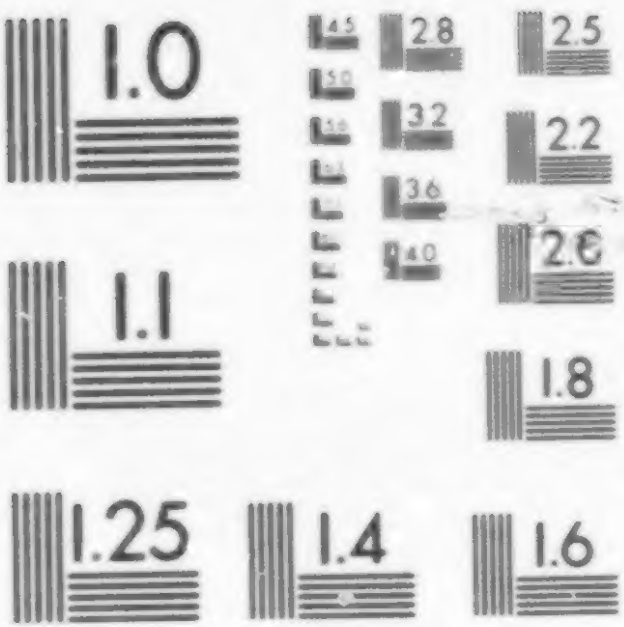
Another aspect of the financing of primary as well as other levels of care, which in some countries of the Region has been receiving considerable attention, is the respective roles of the public and private sectors where a national health service exists, and to a lesser extent in countries with a universal health insurance system. Most countries of the Region, including some of the socialist countries, permit the private practice of medicine. In countries with a pluralistic system private practice is the rule, although most of a doctor's income may come from social or private insurance. In those socialist countries where private practice is tolerated, it is strictly regulated and its scope limited by law. In countries where private practice coexists with a national health service, it is, especially in times of economic pressure, seen as relieving the public system – a rather narrow policy because it merely means a transfer of the cost from one sector of the economy to another without reducing the total cost to society. Furthermore, it is argued that a competing private sector syphons off resources from the public services for the benefit only of those who can pay for it. These issues have occupied the political scene in the United Kingdom, as cuts in the public service lead more and more people to seek compensation in the private sector.

Financial incentives of some kind are used in various countries to attract doctors and other personnel to primary care practice in otherwise less desirable areas, traditionally the more remote rural areas but increasingly also the declining parts of inner cities. Higher pay alone does not seem sufficient to overcome the disadvantages of practising in such areas, but the provision of other amenities, including housing, practice premises and equipment, may be more effective. The establishment of health centres in otherwise medically deprived areas and the provision of accommodation in shopping facilities mentioned earlier may, together with financial inducements, be an effective means of correcting maldistribution of primary care resources. The methods in a particular system depend on its general policy on financing (*7*).

The discussion so far has concerned itself with general aspects of financing, which in some ways affect primary care and its organization in the countries of the European Region. The following sections describe specific features observed in selected countries within each of the three major types of health service system existing in the Region.

The socialist countries of eastern Europe

In the socialist countries the health services are part and parcel of societal activities, the financing of which fits into an overall plan.



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STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

Centrally promulgated norms and standards provide the framework within which local budgets are prepared, to be consolidated at the next higher level and ultimately to result in a comprehensive national plan. In countries with a federal constitution, such as the USSR and Yugoslavia, the constituent republics exercise a certain degree of autonomy, and this is extended in Yugoslavia—with appropriate checks and balances—to the individual self-governing health institutions. There is, therefore, a certain similarity among these countries in the budgeting process, although specific norms and standards vary according to the individual country's needs and available resources. Budgeting is simplified by the existence of accepted standards, and financing by the fact that facilities are publicly owned and all personnel are public employees with fixed salaries and wages.

The USSR exemplifies the basic pattern of budgeting for and financing health services in the socialist countries, although the procedures and underlying specific criteria vary from country to country in accordance with their different needs and institutions.

The distinction between norms and standards, as used in the USSR, is that the former represent scientifically established indices of health care requirements and utilization, whereas standards are indices relating to the resources needed to satisfy the norms (*8*). Examples of norms applicable to primary care are those relating to the need for immunization or epidemiological investigations, requirements for community medical care in outpatient facilities and dispensaries, hourly workloads of physicians, or the need for drugs, dressings or other treatment. Corresponding standards would relate to the establishment of primary care facilities, the number of medical and other personnel required, medical and other equipment required, furnishings and transport, and construction and maintenance requirements. Allowing for some flexibility to adapt to local situations, these are the guidelines for budgeting at the local level.

At the beginning of the fiscal year the local administrative level (*rayon*) is notified of its allocation for health. The finance officer is responsible for controlling its use, and auditors check periodically to ensure that proper allocations are made to individual institutions. The health budget amounts to about one third of the total local (*rayon* and *oblast*) budget; the percentage gradually decreases with higher administrative levels because of their wider responsibilities in other sectors. In addition to the funds allocated through the central planning mechanism, local services are also strengthened by financial support from major industries, as well as from state and collective farms for their employees. Trade unions, too, operate health institutions for their members and contribute to health promotion among them (*9*). A major role in monitoring the allocation and use of funds is assumed by the chief physician of the *rayon* (*10*).

Similar methods of budgeting based on sets of norms and standards are used in the other socialist countries, although the actual scope of these guidelines varies.

Thus, in Bulgaria the basis for budgeting is stated to be the amount of services rendered, with the financing of each outpatient institution channelled through the respective state organ (people's council) to which it is subordinate. There is a set of financial norms for the different types of polyclinic services. The head of the institution determines the expenditure of the funds allocated, in compliance with the plan and according to need.

In Czechoslovakia the funds required for the construction and operation of health facilities, including community health centres and polyclinics, form part of the budget of the District Institute of National Health. An exception is the capital expenditure for the construction of factory health facilities, which are financed by the firms concerned; the firms also contribute to the cost of such items as power supply, maintenance and cleaning. Equipment, drugs, sanitary materials and the salaries of health personnel are paid by the state health administration. Construction of rural health facilities, such as health centres, may exceptionally be financed by agricultural cooperatives, with self-help construction work contributed by the community.

Personnel of all first contact health facilities are paid by the District Institute of National Health from state funds. Salary levels vary with the category of health worker, length of service and possibly also with special difficulties inherent in a particular post. In addition to these fixed sums there is provision for various special payments relating to the quality of work and also possibly for personnel acting as locum tenentes. Extra payment is also made for certain emergency medical services, such as night and holiday duty, taken in turn by almost all first contact physicians.

To the patient, primary care is generally provided free of charge but there is a nominal fee for prescriptions, and patients are required to contribute to the cost of certain dental prosthetic appliances. When a patient is referred to a health facility outside his place of residence, for instance on being referred from a rural health centre to an urban polyclinic, he is entitled to claim reimbursement of his public transport fare from the state health administration (*11*).

The Institute for Social Hygiene and Organization of Health Protection of the German Democratic Republic shows (*12*) that expenditure in that country for health and social affairs has risen steadily since 1950 in line with national income, of which it has constituted in recent years a fairly steady 5–6%. There have been, however, remarkable shifts within the health and social budget: while expenditure for general hospitals increased about three-fold between 1955 and 1978, that for primary care facilities—polyclinics, outpatient clinics, doctors' offices and communal nursing stations—grew about fourteen-fold during the same period.

Treatment at primary care establishments in the German Democratic Republic is free. According to the Ministry of Public Health, expenditure for state outpatient establishments increased from 1.09 million marks in 1971 to 1.55 million in 1975. In the occupational health

services, personnel and materials are financed from the national budget. Prescribed drugs, preparations and medical appliances are paid for by social insurance, whereas all other operational and treatment costs are borne by the state owned enterprises.

In Hungary, as in all countries with a centrally planned economy, the financing of primary care services falls within the framework of the national budget. Each county has its own income from its industries and from local city councils, which contribute to the funds for county development. The national council contributes "target oriented funds", mostly for capital expenditure. While the national budget ensures uniform standards, each council finances its own services. The operating expenses of district health services are thus covered by the local council budgets. Voluntary labour sometimes contributes substantially to health centre construction and special contributions may be received from local industries; in one case, for example, a factory provided roofing material for the health centre at cost. Salaries for health personnel vary according to age, length of service and special circumstances such as work in mines or certain factories. Doctors and dentists may be permitted to enter private practice after working full-time in the national health service; permission from the local council, which also inspects the premises, is necessary.

In Yugoslavia operating expenses of health institutions are funded essentially from insurance funds. Capital for construction, extension or modernization of existing facilities is allocated on the basis of the social agreements or compacts in which health institutions participate with the local administration and other organizations such as local industries, which may co-finance programmes of particular concern to them.

Other European countries with a national health service

As with the socialist countries, there are differences among these countries in the way money is raised for the health services, including primary care, and the degree of local responsibility. It may be predominantly through general revenue, as in the United Kingdom, or by insurance premiums or earmarked taxes as in the Scandinavian countries. The latter countries are also characterized by the considerable degree of local responsibility for the provision of health services.

In 1967 the county councils in Sweden took over the system of district medical officers, who had previously been employed by the government. These officers also provide primary care. In that year, the councils also assumed responsibility for mental health care, leaving the county council with the main responsibility for health services, apart from privately practising physicians and dentists. The health services are financed mainly through local taxes levied by the counties, about 80% of whose expenditure goes on the health services. Part of this expenditure is reimbursed through the health insurance system, particularly for the cost of medicines. The central government uses an equalizing system to give greater financial support to counties with a

high percentage of elderly people and lower economic activity. Fees collected from patients, especially for pharmaceuticals and certain dental services, constitute a steadily diminishing share of the county councils' incomes. All physicians in the public sector are salaried (*13–16*).

In its argumentation leading to Finland's Public Health Act of 1972, the government expected to stimulate the use of general practitioner services by abolishing previously existing charges to the patient because "the effect of charges in delaying the seeking of care has been particularly great among patients of small means". The aim was to abolish charges by general practitioners and to extend free dental care to persons over 16 years of age.

While in Finland the creation and operation of health centres according to the 1972 legislation is the responsibility of the commune or a federation of communes, the state contributes between 39% and 70% depending on the general solvency classification of the commune. Announced government policy in respect of these subsidies was that charges collected from patients at the health centre would be deducted from running costs for the purpose of determining the amount of state support; the same was to apply to reimbursements received by the centre for services provided under the sickness insurance act. The state was to pay monthly advances toward the running costs of centres, calculated as one twelfth of the total of the preceding year's support. Statutory provision may be made for health centres to make charges for transport, for materials or appliances used, and for the upkeep of a patient at a health centre. Doctors are salaried, with extra allowances for overtime work. Provisions for state assistance for capital expenditure, machinery and equipment, and specifications for eligible running costs are detailed in paragraphs 30–39 of the Act (*17*).

Like the German Democratic Republic, Finland is devoting increasing proportions of the health budget to primary care. Primary care grants were estimated to have grown by 687% between 1972 and 1979, compared to a 52% growth for hospital care and a total growth rate for the health sector of 106% during the same period (*18*).

In Denmark, following legislation introduced in 1973, the county councils have assumed functions similar to those in Sweden as regards raising taxes and the financing of health services. The remuneration of general practitioners, of whom an increasing proportion practise in groups, is based on an interesting distinction between the city of Copenhagen and the remaining parts of the country. In the former, practitioners are paid on a per capita basis, whereas elsewhere about half the remuneration is on a per capita basis—lower, of course, than that in Copenhagen—and the rest is based on a negotiated tariff of fees for specified services. This dual payment system, which has a long tradition in Denmark, is explained by findings that suggest the per capita method to be more appropriate in the city, where practise conditions are reasonably homogeneous and the workload more evenly spread, whereas equity among rural doctors is seen to be better achieved by the addition of a fee-for-service element (*19*). Under both systems of

remuneration, doctors are responsible for the running expenses of their practices and their own pension benefits.

In Iceland the capital cost of health centres, where more and more family physicians practise, is shared between the state (85%) and the local authority (15%). Doctors in health centres are employed by the state and, like other members of the team, are paid a salary. The local community is responsible for the running of the health centres, but physicians, nurses and midwives (nurse/midwives) are appointed by the Minister of Health and Social Security and remunerated by the state for preventive work. For their curative work, physicians are paid on a fee-for-service basis by the social security administration, which is a branch of the Ministry of Health and Social Security. All other staff (secretarial and clerical staff, laboratory and X-ray technicians, administrative and maintenance personnel, etc.) are paid by the local authority.

Under the British National Health Service the basic form of remuneration of general practitioners is the capitation fee, modified to an increasing extent by additional payments for specified purposes, relating both to the services rendered by the physician and the establishment of his practice. As distinct from the Nordic countries, health services in the United Kingdom are financed almost entirely (88%) from general government taxation, the remainder coming from national insurance contributions (about 10%) and direct charges to patients (2%) for prescriptions and dental services, from which vulnerable population groups are exempted. There also is a private sector, amounting to the equivalent of about 4% of National Health Service expenditure, largely in the area of specialist and hospital services.

The remuneration of general practitioners by a capitation fee maintains a tradition established in earlier insurance schemes in the country. Extra payments relate to incentives to attract doctors to underserved areas, to the greater demand by the elderly on a doctor's list, to newly assumed activities such as family planning, and to certain other activities accounting for increased demands. General practitioners in the United Kingdom are not employed by the government but are under contract to the National Health Service. They are in principle responsible for establishing and running their own practices, but here again they receive government support in a variety of forms. Group practice, for instance, is encouraged by weighting doctors' fees and allowances, and there are financial incentives to employ support staff and to improve the standard of premises. Thus, 70% of the salaries of up to two full-time staff per practitioner, or the equivalent in part-time staff, are reimbursed by the health authority. This encourages the employment of trained personnel including nurses, health visitors, secretaries and receptionists. Alternatively, other members of the primary care team may be seconded to a practice by the relevant authority. Various government sponsored schemes provide funds for group practice premises, but some practitioners prefer private capital financing to preserve greater independence from the health authority.

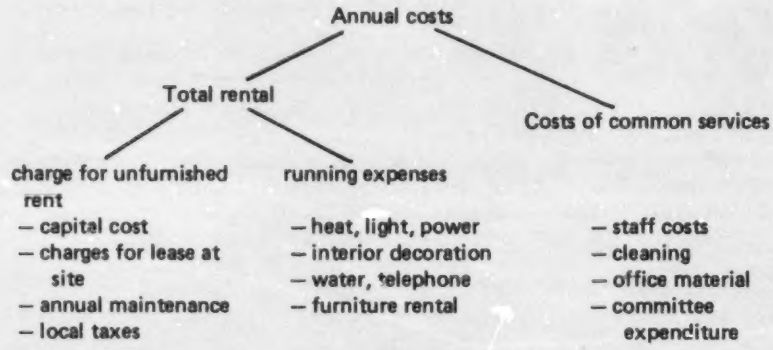
Practitioners are also directly reimbursed for actual or estimated rent and local taxes paid on their premises. In contrast to privately arranged group practices, formal health centres are provided by the Area Health Authority and running costs financed out of the Regional Health Authority's revenue allocation. Consulting rooms for general practitioners and shared rooms in a centre are available under licence, i.e. practitioners pay a charge for accommodation, which is fully reimbursed together with a service charge for heating, lighting, telephone, cleaning, decoration and repairs. This rather complicated arrangement, the Ministry explains, results from the profession's insistence that a practitioner shall not derive financial advantage over his group practice colleagues from working in a health centre. It reflects the fear on the part of some members of the profession of undue regimentation were they to practice in the more tightly controlled setting of a health centre. In addition, however, the various charges to doctors practising in a health centre may well be higher than corresponding charges in private—if poorer—premises, and doctors may have less control over such expenditure when practising in a centre. Some practitioners are also reported to prefer owning their practice to working in a health centre because ownership would enable them to preserve capital for their retirement.

The somewhat ambivalent attitude towards health centres in the United Kingdom has two sources: the jealously guarded independence on the part of the practitioners and the financial constraints on the National Health Service. The latter is quite willing to assist with the capital funding of cheaper private premises rather than the building of new centres. Therefore, the government is also willing to provide funds for converting existing premises for use as health centres, for providing general practitioner premises in National Health Service buildings already accommodating district nurses and health visitors, or to accommodate nurses and other primary care services in proximity to existing general practitioner premises (*20*).

Scotland, with its smaller population, has always had a simpler organizational structure than the former district–area–region tiers in England. It has also been more emphatic in its health centre policy, and more specific information is available on the financial aspects of the operation of some of its health centres. The particular financial arrangements reported relate to the initial period of operation before the reorganization of the National Health Service in 1974, so that some of the agencies involved will have changed in the meantime; the basic principles of financing, however, will not have altered.

One of the centres described (*21*) is located in the city of Glasgow. An interim management committee was established prior to the opening of the centre and a number of subcommittees were set up. After the centre was occupied, a permanent management committee was formed. The health authority provided the capital for the building and equipment. The annual running costs to the occupiers of the centre are made up of the elements shown in Fig. 4.

Fig. 4. Annual costs of a Glasgow centre



The occupying doctors are fully reimbursed for the rent of unfurnished premises. It was agreed that the management committee should be regarded as the supplier of services, and certain rules were agreed on regarding the distribution of charges for these items to the practitioners in the centre. Clerical staff costs were to be divided in proportion to the staff time likely to be required by the practitioners. Cleaning of fully shared accommodation was to be charged on the basis of floor area, but for partially shared accommodation charges would be divided by the same formula as used for staff costs. Each quarter an analysis of expenditure was to be made and expenditure allocated on the agreed basis. An individual practitioner's share of the respective expenditures is calculated according to the number of patients on his list. The management committee also had to look for the most economical way of purchasing materials and equipment, and to establish priorities among competing demands from several subcommittees.

Methods of allocating shared expenditure among several agencies occupying a centre are described for another Scottish centre (*22*) where, furthermore, the then Regional Hospital Board assumed the cost of operating the centre's computer-assisted medical record system.

These arrangements are, as stated before, peculiar to the British National Health Service because of the special position held in that system by general practitioners. They have little relevance for other national health service systems, but have been described here in some detail because of possible applications in countries without a national health service, where the state may wish to create health centres to accommodate otherwise independent private practitioners.

In those areas of Turkey where health services are provided by the government, both the physical facilities and the staff of general and maternal and child health centres are government financed.

Pluralistic health care systems

In these countries the general pattern is one of predominantly private practice, with private responsibility for capital and running costs, the latter being largely derived from various sickness insurance arrangements. In addition, however, most such countries in the European Region have health centres or clinics established and operated by public, semi-public or private agencies, where the sponsoring agency assumes total financial responsibility.

Sickness insurance funds accrue, with relatively minor exceptions, to those physicians and dentists who are under contract to a sickness insurance carrier or, of course, those who are employed at one of the sponsored facilities mentioned above. In Austria, for instance, over 80% of physicians and dentists in "free practice" are under contract to sickness insurance bodies. In that country sickness insurance carriers operate their own health centres where, in 1969, services were provided by 1318 specialists, dental specialists and dentists (*23*). Outpatient departments of public hospitals in Austria are also available to the insured population. Some 25% of all sickness insurance payments in 1973 went for physicians' services, and 16% for dental care. Physicians' services were the fastest growing item of expenditure (*24*).

The financing of health care in general, and primary care in particular, in the Federal Republic of Germany is predominantly taken care of by compulsory "social insurance", a blend of insurance principles and considerations of necessary social adjustment. This system is supplemented by funding by the *Länder* of certain services where they share responsibility with the local authorities as, for instance, in regard to mental health and tuberculosis services. In addition, about 6–8% of the population have voluntary private insurance, and there are direct payments by patients in the private sector. Doctors in private practice who wish to participate in the insurance system, as practically all do, form an association that contracts with the social insurance funds. These doctors remain self-employed and provide their services as medical contractors with the insurance funds. The remuneration of doctors is based on negotiated tariffs and depends entirely on the service performed rather than on the doctor's status as general practitioner or specialist. Insurance covers the cost of all medical care considered necessary. It derives its funds from earnings-based contributions from employers and employees, with special arrangements for pensioners and other groups. Dependants are entitled to the same benefits as the insured. To receive care, the insured or his dependant obtains a certificate from the insurance carrier and presents it to a doctor of his choice who is registered with the insurance fund. Based on the service rendered, the doctor is reimbursed by his association of insurance doctors. About 10% of the doctors' work, and on average about 20% of his income, come from private services paid for directly or by voluntary insurance.

Acceptance of new forms of collective medical practice has been slow

in the Federal Republic of Germany. Since most doctors derive the major part of their income through their patients' insurance funds, the policy of these funds regarding group practice is important. While regulations, as they stood in 1977, do not recognize pooled medical practice (as distinct from common use of auxiliary personnel, equipment or facilities) (*25*), recommendations have been made to promote common and even multispecialty practice.

Certain innovative ways of organizing health and social care in the community in the Federal Republic of Germany require ad hoc arrangements for funding from a variety of sources. Examples are the *Sozialstationen*, which provide nursing and ancillary services on referral by a doctor in the community who, however, is not on the staff of the station and is remunerated in his own right. In part, these stations are subsidized by the *Länder*, whose policy is exemplified by the following guidelines from Rheinland-Pfalz (*26*). The *Land* provides subsidies to *Sozialstationen* for capital and running costs. Stations are required to charge for services and larger items of equipment, but not for mere consultations. Exceptions are made for indigents according to their means. Stations are expected to recover insurance benefits and to liaise with social service departments regarding their services. Capital subsidies may amount to 50%, with a maximum of DM 3000 per motor vehicle. Operating costs are subsidized in terms of fixed amounts for the various categories of personnel. Stations are required to follow prescribed reporting and licensing procedures. The remainder of the funds must be obtained from other sources, including the county and local authorities, the church, insurance bodies, membership contributions, and various fund raising activities (*27*).

The assumption by third parties, especially those under public auspices, of responsibility for the financing of health services inevitably implies some controls. And controls become more stringent in times of economic constraint. In the Federal Republic of Germany, as elsewhere in the European Region, there has been apprehension among the medical profession lest financial controls lead to an infringement of the physician's clinical freedom. Like insurance carriers in other countries, those in the Federal Republic compare accounts submitted by physicians against profiles based on general experience, and substantial deviations may be disallowed. A federal court (*Bundesozialgericht*) in a decision of 1st March 1979 declared that checks of that sort must not lead to a restriction of clinical freedom, within the need to maintain the economic operation of the system. In other words, deviation from the norm does not automatically preclude reimbursement but may be justified in individual cases (*28*). On a different plane, the medical profession complains that the schedule of fees reimbursed by insurance funds does not keep pace with the sharply increased running costs of medical practice (*29*).

Similar areas of conflict exist in France, as illustrated by a strike by doctors protesting against government control of prescribing practices. Doctors and dentists in independent practice are generally paid by the

patient who is then reimbursed by the insurance system, except for his co-payment of the *ticket modérateur* from which certain chronic conditions are exempt. Some population groups, such as public employees, take out private insurance cover for this co-payment through the *mutuelles*, which also operate their own health centres. Sickness insurance is compulsory and, for employees, financed jointly by employers and employees, with contributions by the state. Some health centres are sponsored by the social security system or a local commune. To give an example of one commune-sponsored centre in the vicinity of Paris, the payment for services is on a fee-for-service basis by insurance carriers. The *ticket modérateur*, with its exemptions, in this case amounts to 7%. Capital costs, equipment, instruments, etc. are financed by the commune, which also covers any deficit; staff, including doctors, are salaried. Maternal and child care services are paid for by the government. Crèche services are paid for on a day-fee basis with the deficit also borne by the commune.

It is essentially the sponsoring agency that assumes the capital cost of clinics or health centres in France, possibly aided by local public or private organizations. The operating costs are covered by insurance carriers, with contributions from patients. Any deficit may also be covered by the sponsoring organization. Because the fee schedules of the insurance carriers do not cover such activities as health education, epidemiological studies, case conferences and other preventive activities, these fields are poorly developed in primary care institutions. Dispensaries, devoted primarily to prevention and follow-up for certain disease categories, are publicly funded. In Paris half the funds for these institutions come from the city, the remainder being divided between the state and social security; the staff are employed by the prefecture.

Dental clinics in Paris operated by the social security administration also receive their payment on a fee-for-service basis, but all personnel are salaried. Social insurance pays for services according to the tariff, except for the *ticket modérateur*, which amounts to 20% in this case and, subject to a means test, is covered by social assistance. Because of the sharp rise in costs during recent years, there is a substantial deficit; this is covered by the sponsoring agency but it does put constraints on the services provided.

Maternal and child health centres are financed entirely through social security and are free.

General health centres in Paris operated by the social security system, where full-time staff are salaried and part-time specialists are paid by the hour, receive payment on a fee-for-service basis through social insurance, except for the 20% *ticket modérateur*.

A system similar to that in France, based on the *ticket modérateur*, operates in Belgium; services are paid for by insurance in accordance with a tariff agreed on with the social security administration. As in France and other countries with insurance systems this tariff, confined as it is to curative activities and procedures, limits the ability of a primary care establishment to provide other services not contained in the tariff,

such as preventive measures, health education, etc. Health centres generally receive no other outside financial support, so that any additional activities are left entirely to the initiative of the doctors and other team members. Certain centres do receive occasional support for building costs, personnel and other items of expenditure from outside sources such as local or regional government, mutual societies and universities, but such support is limited in amount and duration.

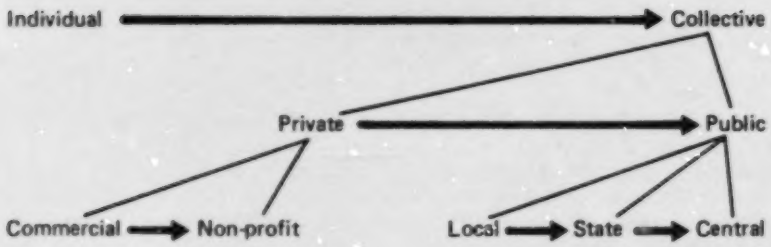
In the Republic of Ireland, the traditional system of general practice by independent practitioners goes hand in hand with the government's encouragement of the development of health centres. General practitioners are encouraged to provide their own practice premises with the aid of grants. Health boards offer practice premises in new health centres for general practitioners who are members of a group practice. Premises are also provided as a means of attracting doctors to underserved areas.

The Netherlands finances primary care largely through various non-profit sick funds, general practitioners in independent practice being remunerated by a capitation fee. Special checks of prescribing practices are made by sickness funds, and some of the larger funds have special committees to deal with what they consider objectionable practices.

The range of financing mechanisms

At one end of the scale on which one may arrange the mechanisms for financing primary care in the countries of the European Region are the fully socialized health care systems, where all facilities are owned and operated and all personnel employed by the state. At the other end there are the systems under which the patient is responsible for paying for the services he receives, although he may be reimbursed under a variety of insurance arrangements. The distinction is partly between a national health service and some provision for paying for the services of independent practitioners. In countries that do not have a national health service there appears to be a definite trend in the methods of financing the health services. This trend is away from personal, individual arrangements towards collective forms of insurance with increasing participation of the public sector. Fig. 5 depicts these shifts. Recently, however, there have been instances of a slowing down or even reversal of that trend in some countries of the Region. An example is the United Kingdom where, as in other parts of the world, a conservative government, in order to reduce public spending, encourages private sector health care. Certain other countries are increasing the practice of user charges. The former approach is purely cosmetic, however, since it does not in itself reduce the total cost of health care to society. User charges, on the other hand, are a very controversial tax on the sick and a potential deterrent to needed use of the service. Similar is the distinction between payment by the recipient for services received and indirect payment; the latter may be through charity, employment insurance, voluntary insurance, compulsory insurance, or government financing (7).

Fig. 5. Alternative channels for funding health care



From the review of the European scene it becomes clear that the existing systems do not fit neatly into any one category, but that most contain elements based on different principles and policies. If there is a trend towards greater involvement of the public sector in both the provision and the financing of primary care services, it may be due partly to the gradual acceptance of the principle of every citizen's right to health care, but partly also to the growing complexity and cost of health service which make it increasingly difficult for the individual to cope. The variety of arrangements existing in the Region, as well as within individual countries, illustrates the wide range of possible alternatives to suit any sociopolitical economic configuration. Differences in the philosophy on which health systems are built do not rule out international cooperation and there is ample room and opportunity for identifying common approaches to common needs (*4*). Models, aided by operational research and systems analysis, can help in identifying components of other systems that may merit adoption. "We are now on the threshold of a truly quantitative revolution in health care and the new numerical methods must be employed in modelling health care systems . . ." (*1*).

What then is the effect of different financing mechanisms on the care provided and its organization? These are issues not confined to the European Region or indeed to any one part of the world. In the United States, the promotion of the health centre concept in the form of the health maintenance organization is largely based on the finding that prepaid group practice organizations reduce the demand for costly hospital services without impairing the care provided to patients. In one of its more recent policy statements the American Public Health Association accordingly urged improvements in the organization of

ambulatory care because of its cost containment significance as an alternative to hospitalization (*30*). Individuals or groups may join such health maintenance organizations in the United States for the periodic payment of a fixed sum (often paid or contributed to by employers as a fringe benefit). In return the members receive the full range of services they need, both medical and hospital care. Costs are kept low because of various incentives and the strict budgets within which the organization operates.

A Canadian study inquiring into the economics of group practice in one of the provinces found that "complex multi-specialty clinics, and particularly consumer sponsored clinics, do have economies in clinic operation which result in higher investigative costs but lower hospitalization rates" (*31*). This is looking purely at the economic aspects without regard to the quality of care. And purely from the cost point of view, the study finds that the lower rates of hospitalization for investigative and non-surgical conditions are largely offset by the groups' higher investigative and consultative or referred costs. Nevertheless, the authors conclude with the comment on the present pluralistic system existing in Canada, that the country may have no alternative and "although the precise effect of group practice in general and community health centres in particular is not clear, the data of this study and other Canadian studies suggest to the authors that the incorporation of these centres into a rationalised Canadian health care system could produce greater returns than anticipated". It may be noted that Australia, under its Commonwealth Community Health Program, assists in the financing of health centres through commonwealth and state grants, the operating costs being met largely from patients' fees, rent paid by professionals using the centres, and donations (*32*). Japan is gradually changing the concept of health centres originally designed to provide preventive services of the traditional public health service type into facilities offering comprehensive primary care services (*33*).

If the development of health centres and similar forms of primary care organization is widely promoted throughout the world, it is because of the need to marshall rationally the resources necessary to enable primary care to fulfil its functions. The prominent role primary care has to play in the provision of comprehensive and balanced services, and the need for teamwork, outreach and coordination with other community services, demand an effective organization to guarantee the quality of the services; cost saving is not the main consideration. When evaluating health centres in terms of their cost, including personnel and equipment, the range and volume of services must, of course, be taken into account. If health centres help to reduce the rate of hospitalization to a greater extent than, say, solo practice, there is likely to be a saving of costs; "however, to find out whether the more economical services provide lesser or greater benefits than those that cost more is a task requiring much further research" (*3*).

Another aspect of financing primary care, which in some countries of the European Region arouses considerable controversy, is the method of

remunerating physicians. The methods range from a fixed salary to capitation fees to strict payment for each item of service, whereby the fees to be paid may be negotiated with the government or an insurance carrier, or may be set at the discretion of the attending doctor. In reality, one finds that the prevailing methods of payment often modify these basic types quite considerably. The advantages and disadvantages of various payment methods have been studied and discussed (*5*, *6*). In many cases the prevailing method is that with a tradition in a particular country, its use often being maintained to make other changes in the system more palatable to the medical profession. It remains difficult to understand, however, why doctors, with all their training and concern with human wellbeing, should require incentives different from those provided to most other professionals and even to some of their colleagues who work in different settings.

Among the recommendations emanating from the Alma-Ata Conference in 1978, No. 17 deals with resources for primary care (*34*):

> The Conference,
> Recognizing that the implementation of primary health care requires the effective mobilization of resources bearing on health,
> RECOMMENDS that, as an expression of their political determination to promote the primary health care approach, governments, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to underserved communities; encourage and support various ways of financing primary health care, including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximize the efficiency and effectiveness of health-related activities in all sectors.

It is with some satisfaction that one notes priority being indeed given in many countries of the European Region to the strengthening of primary care. This chapter, it is hoped, will assist in assessing "various ways of financing primary health care".

On the road towards health for all by the year 2000, it is as well to bear in mind the principles and essential issues formulated by the WHO Regional Committee for Europe (*35*) and by the Executive Board of WHO (*36*) to serve as strategies towards the attainment of that goal. This may involve a reorientation of the existing health system, where it is particularly important to ensure "that primary health care and its support do not become a parallel system that is a 'poor relation' of the existing system. In ensuring adequate support to primary health care at all levels, governments will no doubt have to face the realities of the existing health system, whose functions and emphases may differ greatly from those required to implement the new policies, strategies and plans of action" (*37*).

The various aspects of financing—such as sources of funding, methods of remunerating staff, incentives, and the financial responsibilities of patients—are usually interdependent. Health centres in

the narrower sense, namely primary care facilities under public auspices, can be expected to be financed from public sources; their staff are usually salaried, and services are provided free of charge or possibly for a fixed fee.

Modifications do exist, however, in all these regards and especially in facilities not operated by governments. Funding, for instance, may come from general tax revenue or earmarked taxes; the rationale for the latter is usually that potential consumers are more aware of the cost of service, but it also keeps the health care budget clearly separate from other commitments of the central or local government. There is also a tendency to have primary care facilities wholly or partially financed by local rather than central government as a means of suiting the service to local needs and, again, of creating among the population served an awareness of the resources required.

As to the remuneration of the health centre staff, fixed amounts are the rule for most categories of personnel. Exceptions exist for doctors and dentists, but in publicly administered centres salary or sessional pay for part-time work is the most common form of remuneration, modified not infrequently by extra payments for special services such as house calls, night calls, etc. Special incentives may be instituted, for example to attract staff to remote or otherwise undesirable areas. In the less structured facilities, such as various forms of partnership particularly in the private sector, various other forms of remuneration exist, including fee-for-service payment. The Finnish example demonstrates one particular advantage of the salary method for all categories of staff, which puts all members of the primary care team on the same basis as far as the method of remuneration is concerned.

The method by which a centre receives its funding may be unrelated to the way the staff is remunerated. The centre may receive its payments on a fee-for-service basis from an insurance carrier or patients but the staff, including doctors, may be on a fixed income. Alternatively, the reverse may be the case, with the centre operating on a fixed budget while remunerating its medical or dental staff according to services provided.

How the necessary financial support can best be allocated to primary care and its institutions may well be a worthwhile subject for further study to enable both the WHO regional offices and WHO headquarters to provide Member States with the kind of guidance envisaged by the Executive Board.

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10

External relationships

Whatever the pattern of primary health care practice, from the solo practitioner to the multispecialty polyclinic, it has to relate to other parts of the health care system through referral, and maintain lines of communication with financing agencies, licensing bodies and other agencies. In addition to these basic and essential relationships, there are many others resulting from and depending on the scope and nature of the services provided and the position of primary care, not only within a particular health service but also within the whole sociopolitical setting in which it operates.

No aspect of primary care organization could be discussed without reference to relationships with other institutions or agencies. These relationships have been discussed in earlier parts of this book in the context of the range of services, staffing patterns, teamwork, information systems, policy and decision-making, the administrative structure, relations to the community, and inevitably also financing mechanisms. The basic theme, in fact, in the concept of primary care as it emerged from Alma-Ata and the strategies for health for all by the year 2000, is one of the integration of primary care into the broader social fabric of the community as well as into the other levels of the health care system.

What remain to be discussed are merely some specific arrangements, observed here and there among primary care establishments, that aim to facilitate the necessary communications and make the ensuing relationships operative. A WHO working group listed the relationships between the primary health care team and other health and personal social services (*1*). The group concentrated on relationships arising from the fact that primary care is only part of the health care system—albeit a central part or, as expressed by the Alma-Ata Conference, the key to achieving an acceptable level of health. The working group emphasized the mutual obligations of contact: "they work in both directions, and there must be a constant feedback from one service to another". This cannot be too strongly underlined, because in much of the European Region the feedback to primary care from hospitals, specialists, laboratories, etc. leaves much to be desired; it may not occur at all, or it may be incomplete or not timely. The working group discussed the

subject under the four headings of hospitals, specialists, public health services, and social welfare services.

Regarding relations with the hospital services, the group noted, first of all, that the primary care team should have access to appropriate diagnostic facilities and, as far as possible, their diagnostic findings should be accepted by the hospital and not duplicated after the patient's admission. One can go further by noting that such access to diagnostic facilities may obviate the need for hospital admission. The working group also stated that the primary care team ought to be able to visit patients in hospital so as to maintain contact and preserve some element of continuity of care or concern. This also leaves much to be desired in many European countries because of the often sharp distinction between primary and hospital care.

When discharged from the hospital, the patient should be referred back to his primary physician or primary care team, who should be informed of all treatment given in hospital. One might add that this should be done promptly and also include any instructions for after-care.

Regarding relations with specialist services, the working group listed three important factors:

— the primary physician should know and accept his therapeutic limitations

— the specialist must accept the coordinating and integrating role of the primary physician

— there must be close cooperation between the primary physician and the specialist.

Relations with public health services are discussed here on the assumption that there are separate public health facilities for such preventive personal services as maternal and child care, immunizations, etc. It is important that the work of the primary care team be integrated with that of the public health services, so that in effect they join forces in the care of individual patients. Close personal relations between the two services must be built up.

As to relationships with social welfare services, an undesirable separation is caused in many countries by the fact that the social services, covering a different spectrum from that covered by the health services, often have a different and separate organizational structure. It is important, therefore, for a social worker to be a member of the team. Since this single social worker cannot provide all the social services a patient may require, he must serve to establish and maintain contact between the team and the social services as a whole. It is stressed that this contact at the working level should be supported by parallel coordination at the administrative and planning levels. It may be added that it is particularly important also to overcome problems posed by separate financing mechanisms for the two services where no joint financing exists.

In his review of primary health care in Europe, prepared in the context of the Alma-Ata Conference (*2*) the Regional Director discussed

the relationship between the providers of primary care and the consumers or the community. Only in a few countries does primary care "spring from the community" but there is no clear evidence that this affects the populations concerned in any significant way. The development of an effective relationship is seen as a testing ground for much of the future approach to primary care. There are signs in the European Region, however, of increasing consumer participation either as observers, guardians or advocates of consumer interests or, less often, sharing in the formulation of policy and running the services. The Regional Director also deplores the separation of health and social care since the distinction between medical and social need is rapidly becoming an artificial one, especially in regard to the care needs of the elderly, the handicapped and the mentally disturbed. As a consequence of the widespread separation of primary from hospital care, the relationship between the two sectors is not clear; functions often overlap and "the notion of integration is lost".

Highly structured relationships exist, of course, among primary care, other levels of health care, and a range of other agencies under the various forms of national health service. There is, first of all, the hierarchical structure within the health service system itself, a number of connections to be maintained with other government agencies, and particularly also statutory links with a variety of local administrative and service organizations. Authorities other than those concerned with health may be directly involved in the operation and management of a primary care facility. This may apply to matters relating to the premises of a health centre and even to personnel management. In some European health service systems there is a division of administrative and financial responsibility for health professionals on the one hand and administrative personnel on the other. In Iceland, for instance, physicians, nurses and midwives are appointed and paid by the state, whereas all other staff are employed and paid by the local authority. In Czechoslovakia, administrative personnel are not specifically assigned to particular primary care facilities but form part of the establishment of the Institutes of National Health.

If primary care cannot be considered as a self-contained system because of its links with other parts of the health care system and with other agencies, so the health care system as a whole has links with many other parts of the overall system, including all aspects of national endeavour. These relationships are paralleled at the global level by the links that WHO has come to maintain with other international organizations in technical fields as well as in broader social and economic aspects: the Alma-Ata Conference itself was the result of WHO and UNICEF collaboration.

The socialist countries of eastern Europe

Referral within the primary care sector, i.e. from local to more central units, and referrals from primary to secondary or tertiary levels

of care, are most clearly seen in the highly structured and strictly regionalized systems of the USSR and other socialist countries. At the local level, the feldsher or feldsher–midwife refers to the *učastok* doctor who, in turn, may pass instructions on to the feldsher; he also visits the post regularly and whenever required.

The *učastok* hospital–polyclinic has links with other health services available at that level, such as pharmacies, physiotherapy services, the sanitary and epidemiological station, kindergartens and nurseries. Relations between ambulatory and inpatient care are facilitated by periodic exchanges of medical staff, thus lessening the separation between these two sectors that exists in other health care systems of the European Region.

One of the functions of the polyclinic is the provision of outpatient services for the hospital. It is part of the streamlining of the services and efficiency of operations that pre-admission investigations are carried out as far as possible by the polyclinic. On referral from a polyclinic to the hospital, a case summary is sent to the hospital and on discharge a report from the hospital is sent to the referring polyclinic. To maintain an effective relationship between patients and the primary care facility for purposes of screening, follow-up, etc., volunteers are appointed to maintain contacts with patients residing in their area (*3*).

Reference was made in an earlier part of this book to the cooperation of primary care establishments with other health facilities such as the sanitary and epidemiological stations, as well as among the various primary care establishments themselves such as services for the general adult population, maternal and child care facilities, and the occupational health services in the area. Relations must also be maintained with the various community organizations supporting the health services, and especially voluntary organizations such as the Red Cross and Red Crescent (*4*).

In Czechoslovakia a strictly regionalized system requires and permits linkage between all levels of the system. In such a system the primary physician is either able to manage the diagnosis and treatment of the case himself or has the right and duty to use the consultant services and, in more serious cases, to refer the patient to the appropriate specialists at the hospital polyclinic. The main task of the specialist services at the hospital polyclinic, on the other hand, is to help physicians of first contact to cope with the whole spectrum of prevention, diagnosis, treatment and assessment of work incapacity in their communities. First contact physicians, together with the specialist of the hospital polyclinic, form a team able to solve most local health problems. Those that cannot be dealt with within the district are referred to the regional hospital polyclinic; only very exceptional cases have to be referred beyond the region. First contact physicians can readily consult specialists but the usual procedure is a referral in writing from the first contact physician to the specialist, without the former being present at the consultation. The specialist then enters his information on the patient's record for use by the first contact physician. Physicians working outside the premises

of a polyclinic (e.g. in territorial health centres or industrial health centres) generally contact specialists in writing or by telephone. After discharge of a patient from hospital or at the termination of spa treatment, the first contact physician receives from the hospital or spa a detailed report on the course of treatment of his patient.

The first contact physician also collaborates closely in questions of prevention, origin of infectious diseases and environmental health with personnel of the District Hygiene Station, and he refers patients to spas. Other relationships of the primary care services are those with industrial establishments, the Works Trade Union Council and the social welfare authorities, regarding medical assessment of work incapacity due to illness, pre-employment fitness examinations and assessments for purposes of disability pensions. Contacts with social welfare authorities also concern patients' needs for domiciliary care, including the need for home help to assist with the activities of daily living. First contact physicians, especially the health community paediatricians, also maintain contact with the education system by providing school medical services. The appropriate health community physician completes the medical certificate for the purpose of death registration.

In Czechoslovakia the primary care service is organized by the appropriate District Institute of National Health, and there are plans to create a post of district physician to manage these services. Relations with the population served are facilitated through citizens' committees, through voluntary organizations such as the Red Cross and, in the case of the industrial health service, through the respective trade union organizations.

In the German Democratic Republic too, it is the organization of medical care on a regional basis that facilitates cooperation between the primary care sector and the remainder of the health care system (*5*):

> All specialties participating in outpatient and inpatient treatment are involved in providing primary medical care. Outpatient and inpatient treatment are fully integrated to allow for the coordination of preventive medicine, diagnosis, treatment, follow-up care and rehabilitation.
>
> Medical care is organized on a regional basis. The district territorial unit of primary medical care is supplemented (particularly in the field of outpatient treatment) by factory health centres. Teamwork between physicians of municipal institutions and factories organized on the same administrative lines, joint utilization of diagnostic and therapeutic capacities of local medical facilities, and factory health centres make it possible to provide effective medical care in the residential areas and in factories.
>
> The central facilities of the districts (district hospitals and polyclinics) give systematic guidance to all smaller facilities and organize postgraduate education for all persons working in their districts.

The periodic exchange of physicians between the primary care sector and the hospitals not only serves the purpose of continuous education but also facilitates effective relations between the two sectors.

The Hungarian Ministry of Health also refers to the integrated

network of outpatient and inpatient facilities, i.e. dispensaries, polyclinics and hospitals, all of which form a hierarchical organization with its line relationships. The general practitioner service is subordinate to the professional authority of the director-general of the hospital. This organizational arrangement ensures effective professional relationships since the district health service polyclinic and hospital are all part of the same organization, so that referrals, admissions, transfers, etc. are part of the regular communication system without requiring special provisions. If a patient requires specialist treatment or care in a special institution, the immediate superior of the general practitioner (i.e. the group leader or hospital consultant) may refer the patient to a regional hospital or a specialized national institute. In urgent cases these referrals can be made by the general practitioner himself. The Ministry considers these relationships not at all as external to the primary care facility but as closely integrated levels of one and the same system.

Since all local health and social services in Hungary are linked to the local council—or in cities to the municipal health body—the general practitioner can readily contact other agencies such as the social services or the school health service. Separate school health services are provided only in towns and cities as a youth health service. Primary school children are cared for in larger towns and cities by the district paediatrician, while in the villages the general practitioner looks after every type of school. There is regular reporting by the general practitioner to the appropriate health authority and, in turn, he is provided with the information he requires from other sources. There are regular meetings with the health board of the local council. The industrial physician, besides his immediate contact with management and the sanitary and epidemiological station, is also in contact with the National Institute of Labour Hygiene.

While integration of all levels and branches of the health service has been a guiding principle since the Second World War, increasing specialization and differentiation of institutions rendered the task more complex, especially in the city of Budapest where some institutions have nationwide functions. Paediatric services present special problems of their relationship to other sectors in the capital, and particular attention has therefore been paid to the integration of all branches of the health services and communications among them (*6*).

If health services for children raise particular problems in their relationship to other agencies, health services for the elderly also require that attention be paid to the need for expanding relationships between the health and other community organizations. This is illustrated by the example of a rural community in Romania that has recently become industrialized. Not only does this development necessitate establishing effective relations with the social services, but it also means establishing effective communication with families and the community at large to cope with the broader social and psychological problems, including those arising from the generation gap, to which primary medical care must relate (*7*).

Any effort at a truly effective relationship between primary care and the hospital, and therefore complete integration, must overcome the traditional separation between those two sectors. When this became a problem in the city of Zagreb in the 1960s, it could still be observed that integration existed mainly only on paper: "though repudiating any dualism theoretically, we nevertheless tolerate it in practice" (*8*). Part of the remedy was to create a programme of specialty training in general practice that brought the status of the general practitioner up to that of his specialist colleagues at the polyclinic and hospital. Plans for hospitals in Yugoslavia to have a general practitioner on the staff to do the work of general medicine at admission and screening developed slowly, if at all. The organization of primary care in medical centres was found to facilitate the desired relationships. Integration would not only improve medical care, it was postulated, but would also have financial benefits by pooling certain equipment and administrative services, as well as by avoiding the duplication of diagnostic procedures. Relationships between primary health care, other sectors of the health services and other community activities are framed by the social agreements or compacts that regulate the functions of primary care institutions in accordance with the community social insurance agency, local industry and trade unions, and other community institutions (*9*, *10*). Relations between primary health care and such organizations as the Socialist Alliance of Working People of Yugoslavia, the Conference for the Social Activity of Women, the Confederation of Yugoslav Trade Unions and others facilitate campaigns for blood donors, mass immunization and screening. sanitary measures, etc. Similarly, primary care receives support from the Yugoslav Red Cross and other voluntary organizations. Health education is promoted by the relationship between primary health care and the local school system.

Many of the features found in the health services of the socialist countries also exist to different degrees in other European countries with a national health service. This applies most generally to the vertical relationships within the system, necessarily characterized by hierarchical elements inherent in a national organization with a differentiation of functions between the central, regional and local. Perhaps what distinguishes the socialist systems from their counterparts in other countries is the close integration of the health care system into the framework of central or regional socioeconomic planning, and the consequent lateral relationships at the primary level, as at each other level, with the corresponding civic and political structures.

Other European countries with a national health service

Vertical relationships of primary care with other levels of the system, lines of referral, and the flow of communications are, as mentioned above, essentially similar to those in the socialist countries. There are

differences in detail, however, and with regard to the flow of information the actual practice is often at variance with the established rules; this applies particularly to the flow of information from the specialist or hospital back to the referring primary physician, a flow which is frequently inadequate in terms of content or timing or both. Primary and secondary care are distinctly separated and access by the general practitioner to his patients in hospital is limited to certain conditions. He may be permitted to visit his patients in the hospital, but the treatment stays in the hands of the hospital doctor.

Here again, the health centre organization favours more structured relationships, within both the health care system and other community organizations, than could be maintained by a single-handed practitioner without the logistic support built into the health centre. Also, the very process of erecting a new health centre, and the consultations connected with it, will bring about a closer relationship between the centre and other community organizations than could exist between a general practitioner and the community.

The establishment of some of the health centres in Sweden, which were monitored by academic research institutions and the Swedish Planning and Rationalization Institute of the Health and Social Services (SPRI), involved broad representation of the communities to be served by the centre. An example is the creation of the new centre in Tierp Municipality. The objective of that project was stated as the application of the "totality concept" to the experimental activities and "thereby contributing to the coordination of social welfare, public health, medical care and student care" in the municipality (*11*). A close relationship between the future centre and the various sponsoring organizations was established as early as the planning stage. A "collaboration committee" contained representatives from the municipality, the county council and the National Board of Health and Welfare. A "reference group", responsible for the research and development of the project, comprised members from the research organizations observing the project and from the National Board of Health and Welfare. A "coordinating group" consisted of the head of the local social service office, the registrar of the health centre and the local chief education officer. Collaborative relationships in the operation of the centre between the medical services, social services and student care services were formalized in the above mentioned "coordinating group" as well as in four "area groups", each responsible for a geographical–administrative area within the municipality. These groups comprised a social welfare officer, district nurses and medical officers, home care officers and a school representative, with representatives of other organizations co-opted as required. The social welfare officer of each group was to act as its coordinator and chairman at meetings. To ensure collaboration in the care of individual patients, joint social–medical teams were set up. Early experience with this new type of organizational structure brought out some of the difficulties that became apparent in its operation.

> Ideally, all of the units in the organisation would work under conditions of harmonious co-operation. Such co-operation is difficult to achieve in well-established organisations, and in young organisations special problems may often arise. Channels of information have often not been clearly established, various units in the organisation get under way at different times, and there is an uncertain allocation of responsibility, etc. In spite of the fact that the organisational changes in Tierp were relatively well prepared, numerous problems of this nature were encountered during the introductory period. In addition, large sections of the organisation's environment were inadequately informed on the new work forms.

This illustrates the teething troubles inherent in any restructuring of established relationships. Such a formalized inter-agency organization introduced a new note into community life and it was uncertain how people would react to it.

How are these difficulties to be overcome? Smooth working relationships must evolve from experience and mutual recognition.

> Such questions must be solved within the organisation and its environment (municipal and county bodies, etc.) and in pace with the need and willingness of the organisation to subject the matters to discussion.

As for the conditions for effective collaboration among the primary care team itself, discussed in an earlier part of this book, inter-agency collaboration must also be based on mutual awareness of the distribution of functions and responsibilities; this can be stimulated and supported by a suitable organizational, administrative and financial structure.

Guidelines such as those given in Denmark through the Ministry of the Interior and the Ministry of Social Affairs, and parallel recommendations by the Municipal Councils Association, for planning, cooperation and communication within and between primary and other health care levels, are intended to ensure and stimulate the achievement of a truly comprehensive service at the local level. In particular, this also helps to ensure smooth and effective relationships between the social and health services where both are needed.

Inadequate coordination between the health and social services is a recurrent theme in most countries. In Sweden, social services are the responsibility of the local community, while health services fall under the authority of the county. But there are other problems arising from the dichotomy of social and health care services, some of which are described by the Finnish Ministry of Social Affairs and Health (*12*): personal social services are subject to a wide variety of regulations, are implemented by different organizations, and have remained underdeveloped in comparison with health care due to a lack of adequate planning and funding. All this impedes the care of chronically ill patients, alcoholics, the physically and mentally handicapped, etc. Common regulation and funding of the social and health services would

achieve closer cooperation between the two. Another factor hampering the relations between branches of the health services, and between these and other community services, is frequently the lack of coterminous borders (*13*). Regarding the relationship of primary care centres in Finland, it has been the policy to increase ambulatory services provided by hospitals, decentralize them as needed, and coordinate them with the activities of the health centres. Implementation of this policy has enabled one health centre to make specific arrangements for various services with a number of hospitals. In another centre it was found that community based projects, such as the North Karelia project, are instrumental in bringing general practitioners into regular contact with hospital doctors.

The matter of information exchange between a health centre and other health care institutions regarding referred patients is regulated in paragraph 18 of the Finnish Public Health Act of 1972. The Act also provides for health centres to assist the police in carrying out forensic examinations and, if so requested, to examine those eligible for military service. In its general argumentation leading to the introduction of the Act, the government allowed for agreements to be entered into between communes and schools or places of employment for the provision of health care to students and employees. Such services, except for routine school health services of a supervisory nature (paragraph 14.5 of the Act), should not be obligatory for the commune, and payment should be fixed in any agreement.

Further external relationships of Finnish health centres may arise from agreements between the National Board of Health and a commune maintaining a health centre, regarding the care at the centre of patients from certain institutions.

Special care facilities, such as those for maternal and child care, the mentally ill and tuberculosis, must maintain relationships with other agencies according to the requirements of such special services. The Helsinki City Tuberculosis Dispensary, for instance, lists the following among external bodies with which contact is maintained: the central sanatorium, polyclinics of other hospitals, the city health centre, the city welfare authorities, the police (for inspection of persons refusing treatment), and address bureaux and registers (to help locate patients). These contacts are in addition to those maintained routinely with specialists and hospitals, social welfare authorities, municipal school health services and registration offices.

In the United Kingdom, general practitioners are not employees of the National Health Service but contract with the service to provide their services to patients registered with them. The pattern of practice—solo, group or health centre—is up to the individual practitioner, and consequently there is a wide variety of arrangements by which he may relate to other agencies. Under these circumstances a recent Royal Commission stated that "it would be foolish and unprofitable to try to force general practice into one particular mould" (*14*). The same applies to dentistry in the United Kingdom. Some general practitioners have

periodic sessions in hospitals, and it is thought that the introduction of a hospital practitioner grade will increase hospital work by general practitioners. Consultants from the hospital, on the other hand, may visit patients of general practitioners, and they are even more likely to hold consultant sessions in health centres. There is, as the Commission observed, little cross-boundary work between community and hospital work by other categories of health personnel, although some liaison posts exist and in some local hospitals nurses work both inside and outside the hospital. General practices may employ nurses or they may be employed by the health authority and "attached" to a health centre or group practice.

The relationship between hospitals and the primary care services in the United Kingdom still leaves much to be desired, although their integration was one of the objectives of the reorganization of the service in 1974. The Royal Commission found "frequent criticism of communications across the hospital/community boundary". While there are established procedures for referral back and forth, communications are often inadequate.

Another link maintained by some of the independently practising general practitioners in the United Kingdom is that with a commercial deputizing service, which sometimes raises questions of quality and continuity of care. Special problems exist in regard to the relationship between primary medical care and the social services, since each is administered by a different authority (except in Northern Ireland). Joint consultative committees and overlapping representation on the respective authorities, as well as the availability of (albeit limited) joint financing, aim to overcome the difficulties inherent in this separation.

Sharp separation between general practice and the hospital has been a long-standing feature of the British health care system and it is slow to change. The exclusion of the general practitioner from the hospital "where most of the more spectacular advances in medicine have been made" was deplored by the British Medical Association in 1970 (*15*) and recommendations for improvement were made. "Feelings run high on this question", the report states, "largely because the general practitioner has been excluded from any part in the care of his patients in major hospitals since the inception of the National Health Service, and, indeed, until recently, has had difficulty in gaining access to ordinary diagnostic facilities". These complaints relate largely to the major district hospitals; there are smaller hospitals, general practitioner hospitals, and particularly maternity facilities to which the general practitioner has access. Another point of dissatisfaction among primary care physicians in the United Kingdom is the difficulty in communication with the hospital: "close liaison is essential between the members of the primary health care team and the hospital service, but at present this liaison is frequently negated by the prolonged interval which can occur between the patient being seen at a hospital as an out-patient or being discharged from hospital and the arrival of the consultant's report in the hands of the family doctor" (*16*).

Possible relationships between hospital and community health services in the setting of the British National Health Service were explored, and respective advantages and disadvantages reviewed, in a study on health centres (*17*). The alternatives mentioned are:

- all medical care being incorporated into the hospital service;
- all health services being based on the site of the district general hospital;
- limited duplication in all health centres of services traditionally provided at hospitals (e.g. diagnostic equipment, outpatient sessions, day surgery facilities);
- selective application of the foregoing alternative;
- overlap of personnel, but not of services, between health centres and hospitals; and
- health centres as general practice teaching units.

Advantages and disadvantages, including acceptability to those involved of each of these possible models, make it clear that, apart from policy issues, practicability will depend largely on local circumstances.

A number of health centres in the United Kingdom, especially those sited in proximity to a hospital, are already being used by specialists for their outpatient clinics. Specialists and general practitioners should have the occasion to discuss individual patients or policy regarding the management of certain types of case (*18*). A policy statement by the Department of Health and Social Security established criteria for the siting of health centres in association with a hospital (*19*). In any case, there should be consultation with the community health council. A central location well served by public transport would favour such siting, certainly in the case of a general practitioner hospital. It should be made clear, however, that the centre is not part of the hospital, so that patients will not lose the feeling of coming to their family doctor. Practitioners must be fully informed of future plans for the hospital. Regardless of their siting, health centres should have accommodation for local authority social workers connected with the primary care team.

Pluralistic health care systems

A very loose form of organization and external relationship exists in those countries where the primary care physician, often in solo practice, operates as an independent professional, creating his own relationships with other professionals and agencies. He may, on occasion, request the services of a community nurse employed by a public agency, he may refer a patient to one of the social service stations, or he may refer him to a specialist practising within or outside the hospital. Austrian experience with using the services of a community nurse led to the conclusion that such arrangements may often work well, especially in small communities, but communications may be time consuming and sometimes break down (*20*). Relationships of the general practitioner

with the hospital vary not only from country to country but also within countries according to local conditions and personal arrangements, for instance regarding a general practitioner's visit to his hospitalized patients even though their treatment may be entirely in the hands of the hospital doctor. In general, however, the general practitioner's access to the hospital is limited at best.

Regarding some form of relationship with the community, there is—especially where health centre-like institutions exist—some vague awareness that some rapport with the community should be aimed at for the sake of health promotion but, as the Belgian Ministry puts it, such rapport is difficult to achieve because the population has become accustomed to a passive role *vis-à-vis* the health establishment. Nevertheless, some centres have evolved a variety of relationships ranging from patient committees to informal meetings, distribution of health educational material and some preventive activities, but rarely amounting to participation in management such as organization of the centre, priority setting, programme planning, etc.

There are also charitable and other voluntary groups in these countries that cooperate with and support the activities of public health bodies, centres for social assistance and other community care, or institutions for the care of the elderly. While in the Federal Republic of Germany there is not the clear dividing line as in other countries between the work of the general practitioner and that of the specialist, there is a sharp separation between those practising outside and inside the hospital, with the former having no access to the hospital. Treatment after admission is conducted entirely by the hospital staff.

Doctors at health centres in France, or other primary care physicians, are not normally allowed to see their patients in hospital, but they may refer patients to the hospital of their choice. Referral to hospital or a specialist may be made by a letter of referral, or by sending a photocopy of the patient's record. It should be noted here that some centres, such as the *mutuelles* or L'Institut prophylactique in Paris, have a number of beds at the centre for selected inpatient care. The centres usually maintain good relations with the various public health agencies in their community, including dispensaries, as well as with the social services, which have workers in many of the centres. They also make their services available to other physicians in the community. In most cases, however, liaison with the school health services leaves much to be desired.

In the Netherlands most specialists can admit patients to hospital, and they use hospital facilities for the care of their outpatients. General practitioners may admit maternity cases but they do not work in the hospital, except for visits to their patients who may have been admitted.

With the variety of organizational forms of primary care existing in this group of countries, the relationships with other parts of the health system and other agencies also vary considerably in their nature and extent. This applies in particular to any structural relationship with the community served, however this may be defined. Personal motivation

and initiative on both sides play a major role here. The referral system follows the basic pattern existing elsewhere, except for the general absence of the more-or-less strict regionalization prevailing in countries with a national health service. Also, the general practitioner may not necessarily be the first access doctor in the pluralistic systems. Since most countries in this group have insurance systems of one kind or another, the relationship between the primary care establishment and the insurance carriers assumes greater importance and may in some situations affect the pattern of practice.

Primary care and the larger system

Relationships of any form of primary care facility are conditioned by its role within the system, i.e. the health system as well as society in general. This corresponds partly, though not necessarily entirely, with vertical and horizontal dimensions. Vertical relationships are generally those with other levels of the health service, such as from the primary level to a specialist and/or hospital. Horizontal relationships for the most part extend to other community services and agencies at the local level. Especially for the more peripheral primary care facilities, this distinction often goes hand in hand with communication and referral outside the local community for secondary or tertiary services, or inside the community for other locally provided services.

In both respects, there are differences in relationships among the three broad groups of health care system reviewed here, i.e. the socialist systems of eastern Europe, others with national health service systems, and the pluralistic systems. If this book clarifies any of the issues inherent in the organization of primary care in the European Region, it should be the fact that primary care cannot be discussed and understood without the context of the systems of which it is a part, i.e. the broad societal system and its subsystem concerned with the provision of health services.

The most highly structured relationships are found in the socialist systems with their strict regionalization and defined populations served by the facilities at the various levels. Under these systems the relationship within the health sector is a strict line relationship in an essentially hierarchical organization. Lateral relationships within the local community, on the other hand, are clearly defined by the central planning system, which deals with the health service as an integral part of total societal activity at each level of administration.

Similarly structured vertical relationships within the health care system prevail in those other European countries that have a public national health service. Exceptions are those countries where general practice is an independent profession, so that relationships with other parts and levels of the system are of a contractual rather than a hierarchical nature. Horizontal relationships, however, lie outside the organizational framework provided by the national health service. In some countries, such as Northern Ireland and Poland, health and

personal social services are administratively combined, facilitating the coordination of the two. Great Britain has joint consultative councils intended to bridge the gap between the still separate (and largely also separately financed) health and social services. A beginning has been made with joint funding.

Other countries may have the two services combined at the central level in one ministry, but not at the local level where the social services may be administered by the local authority and health services by the larger county administration, thus rendering working relations between the two more difficult. But even the tenuous ties provided by a combined central health and welfare ministry have no parallel in respect to other community agencies and services that bear on the health of the people, so that the primary medical service and the community at large are left to their own devices regarding any relationship they might develop. That such relationships have nevertheless been established here and there is evidence of a felt need.

In the pluralistic systems there exists neither the hierarchical structure within the health care system nor, generally speaking, a built-in link with other sections of community affairs. The relationships within the health services are confined to unstructured referrals, and rare links with other parts of the community emerge only as a result of local and often personal initiative. They do exist, however, and again they reveal the need for and advantages of the kind of relationship that complements community orientation of the primary care facility with primary care orientation of the community.

The full integration of primary care into the remainder of the health care system (or, vice versa, restructuring of the health care system to fully and most effectively support the primary care services) leaves much to be desired in many countries of the European Region. There is a growing awareness that the development of the concept of primary health care as an integral part of community life, as envisaged at Alma-Ata, is desirable, if not essential, if health for all is to be achieved. All this, however, means building up new relationships and ensuring the will not only of policy-makers but also of those who will have to establish relationships, for which they must be conditioned by their training. Society at large must also be made aware that physical, mental and social wellbeing are indivisible, and that it must do as much as possible to maintain health before relying on medical care to cure or alleviate illness.

Primary care, for its part, must be equipped not only to dispense medical service passively but also to establish and maintain the relationships necessary to play its broader role. The European Region shares this challenge with other parts of the world where the idea of health centres is gaining ground. Several years before the Alma-Ata Conference, a study sponsored by the Canadian government concluded that a health centre must maintain the vertical as well as horizontal relationships described above, i.e. "form part of a responsive and accountable health service system" and "in turn, the health services must be closely and

effectively co-ordinated with the social and related services to help individuals, families and communities deal with the many-sided problems of living" (*21*). The health centres established in the United States under the auspices of the Office of Economic Opportunity are conceived as integral parts of developing socially and economically deprived areas. As in many other countries, health services in Japan have been seen as wanting in the past in several respects: too categorical, separation of curative and preventive services, and too one-sided planning from the administrative and professional points of view. Future needs are described as strengthening of community based health activities, promotion of comprehensive health care, and active participation of the people in health planning (*22*).

The Declaration of Alma-Ata (*23*) describes the highest possible level of health as a social goal "whose realization requires the action of many other social and economic sectors in addition to the health sector". Primary care, the Declaration further states, "involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors".

An integrated, functional and mutually supportive referral system is needed to enable primary care to discharge its functions. The joint report for the Alma-Ata Conference by the Director-General of WHO and the Executive Director of UNICEF (*23*) emphasizes the need for coordination: "primary health care, as an integral part of the health system and of overall social and economic development, will of necessity rest on proper coordination at all levels between the health and all other sectors concerned". And, in turn, primary care must be supported by other sectors of the health system and all the other social and economic sectors. Other sections (86–90) of the joint report describe more specifically the liaison mechanisms and referral system required for primary care to fulfil its functions regarding the relationship to other sectors.

To ensure the necessary two-way support and referral process between the various sectors, the Executive Board of WHO states that "a system needs to be devised that links the various institutions involved" (*24*). This is part of the strategy for achieving health for all by the year 2000. It requires primary health care to maintain multidirectional relationships which, in many countries of the European Region, are as yet only poorly developed or nonexistent. To enable primary care to live up to the role expected of it, it needs two things: the proper orientation and the necessary resources.

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The physician, however well qualified, and the hospital, however well equipped, are no longer sufficient to give the care many people need and modern medicine can provide. Increasingly specialized physicians now operate more sophisticated equipment in health services of such complexity that there is a danger of their losing touch with their patients as whole people. To counter this the concept has been developed of the health team that provides "primary", "ambulatory", or "community" care services outside the hospital. In this book the term "health centre" is used to mean the various forms of organization of services that are outside institutions and provide ambulatory care and care in the patient's home.

This covers a very wide range, from the health centre buildings that have long been part of some health systems, through loosely linked cooperative arrangements with no physical centre, to a variety of demonstration projects that have yet to be assessed or fully implemented. In surveying this range Robert Kohn has provided a mine of information from America through Europe to Japan and from Finland in the north to Algeria in the south. Historically he covers the period from the 1926 experiment at Peckham to the 1978 Conference at Alma-Ata. Philosophically he ranges from Adam Smith to Halfdan Mahler.

This comprehensive picture of the different types of primary care organization will be particularly valuable to those who recognize that their system could be improved. It presents a unique analysis of the follow-up to the Alma-Ata Conference on Primary Health Care that is still very much needed in even the richest country. The book will thus be very helpful to health workers and administrators in Europe and the rest of the developed world, and shows the wide choice that is available to those countries where the primary health care infrastructure is still being established or expanded.